

The Construction of Modern Islamic Authority

*Analyzing the medical ethics of the Islamic
Organization for Medical Sciences*

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Organization for Medical Sciences

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Abstract

Developments within medical technology and worldviews have during the 20th and 21st centuries challenged the definitions of both “life” and “death”. These developments have led to the need for defining new ethics concerning the usages of medical technology and research in relation to ethics of life. The Islamic Organization for Medical Sciences (IOMS) has since the early 1980’s been producing Islamic medical ethics (IME) as ethical frameworks for science and medicine based on Islamic tradition. However, producing such IME has been within an interdisciplinary field of collective reasoning, complementing Islamic “law” and ethics with medical anthropology, social and natural sciences.

During the course of the 23 years from 1981 to 2004 the IOMS (or an early incarnation of it) produced through such collective reasoning two charters, or Codes, of IME pertaining to the practice and behavior of medical professionals. The purpose of this study is to analyze how the authority of those two Codes was constructed with regards to both traditional religious authority and the modern context of medical ethics.

The two Codes were presented and produced within different contexts, to different audiences and through cooperation with different organizations and institutions. By using theories mainly of Bruce Lincoln, Max Weber, Muhammed Qasim Zaman and Alasdair MacIntyre the current study aims to examine the significance of these differences to the constructions of the Codes’ claims to authority. As such, my thesis portrays the authority of the Codes as relying on two interrelated practices within the field of IME: the traditional institutions of Islamic authority, “law” and ethics, and the field of modern medicine and ethics including its organizational structures. A second finding of the current study is that these two practices change in nature according to the contemporary context. The Code of 1981 was framed by an agenda of international, pan-Islamic ethics and politics, and a program of reform and resurgence of Muslim intelligentsia. In 2004, the Code was produced within a larger environment of global medical ethics and organizations such as the WHO. These differences led to a shift of focus, where in 1981 the role of Islam was defined as a source of universal ethics, and over to being one of several discourses on medical ethics in 2004.

These developments led to a larger degree of rationalizing modern science and medicine within the Islamic tradition. The study is partly based on a view of historical continuity and modernity as a symbiotic pair in the development of tradition. Therefore, the rationalizing of modern science and medicine is concluded to be a natural process in the development of traditional, religious authority.

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Chapter 1: Introduction of the study

Theme of the study

Throughout the history of Islam, legal-ethical authorities have been producing statements regarding proper conduct and way of life, both ritually and socially. Historically, figures of authority such as the *muftis* and *qadis* have administered both textual sources of the Islamic tradition and their interpretations. The different law schools and factions within Islam have presented both Muslims and non-Muslims with a diversity of viewpoints on what is Islamic, and why it is Islamic (Hallaq, 2009).

Developments of modern medicine during the last half of the 20th century and continuing into the 21st century have been massive. However, the encouragement of such developments and use of the resulting technology is bound within the moral frameworks of ethics. Such ethics are however not constant. The processes of rationalization and routinization Max Weber theorized in *The Sociology of Religion* (1991) tells us that a continuous religious tradition, claiming relevance to the daily life of the believers, at some point needs to take into account the social, cultural, economic, political and historical context of its intended audience.

I have chosen to place the current study within the field of Islamic medical ethics¹. Furthermore, I have chosen to examine ethical guidelines pertaining to the role of the Muslim doctor, regulating both personal and social aspects of his life. The main purpose of this study is to examine how the authority of those ethical guidelines is constructed, in order to see how religious moral doctrine is viewed in light of contemporary contexts.

Due to the intricacies of modern technological advances, a collectivist trend has emerged within Islamic authority. Instead of individual *muftis* proclaiming *fatwas* based on religious texts and precedent, organizations have been founded to answer modern problems of medical ethics. These organizations gather several types of specialists, both scholars of Islam and of the “secular” sciences. A number of *ulama* (scholars of religious tradition) are usually included, often with different scholarly backgrounds in order for the organization to bridge the gaps and synthesize between the established Islamic law schools. In addition, technical and

¹ The field of studying Islamic bio- and medical ethics has been through a process of critique, identifying its place and rationale within the larger field of studies on religions. Vardit Rispler-Chaim introduced her study of the field with an identification of “Islamic medical ethics” as responding to the challenges of “Islamic medicine” (1993, p. 2). John Kelsay argued that “[...] the current emphasis on distinctively Islamic approaches to medical ethics [...] is more a function of modern Islamic history than a necessary feature of Islamic tradition” (1994, p. 94). Almost twenty years later, Muhammed Ghaly responded to the process of reflexive critique with cementing it as an academic field of study with multiple facets and approaches (2013).

scientific experts from the medical field, as well as representatives of larger international organizations armed with the knowledge of political and organizational bureaucracy are included (Atighetchi, 2007, pp. 8-9; Svensson, 2010, p. 110).

One of the central actors of developing Islamic ethics of medical practice is the Islamic Organization for Medical Sciences, the IOMS (Eich, 2011). Dr. Abdul Rahman Abdulla Al-Awadi, the president of the IOMS, describes the reason behind the creation of the organization as a need to answer question of “Where is Islam's role in sciences in general and in medicine in particular?” and that there had long been a need for an organization able to represent an Islamic point of view in matters of medicine, history and ethics (Al-Awadi, *A Synopsis of the Islamic Organization for Medical Sciences*).

During a span of 23 years, from 1981 to 2004, the IOMS (or an early inception of it) produced two charters, or “Codes”, of Islamic medical ethics. The first of the two Codes was the *Islamic Code of Medical Ethics* (the Code of '81) ratified at the First International Conference of Islamic Medicine (the Conference of '81) held in Kuwait in 1981, and published that same year in *The Proceeding of the First International Conference of Islamic Medicine* (the Proceedings)². The Code of '81 contains general ethical guidelines to be followed by Muslim medical practitioners and other professionals (El-Gendi, Hassan & Kidwai, 1981, pp. 16-18).

The second Code by the IOMS is titled the *International Islamic Code for Medical and Health Ethics* (the Code of '04), and was produced mainly at the Eighth International Conference on Islamic Medicine in Cairo, 2004 (the Conference of '04). It was developed within a larger international cooperation with (mainly) the Eastern Mediterranean Regional Office of the World Health Organization (WHO-EMRO), the Islamic Educational, Scientific and Cultural Organization (ISESCO) and the Council of International Organizations for Medical Sciences, CIOMS (Al-Awadi, *The International Islamic Code for Medical and Health Ethics: FOREWORD*). The Code of '04 was later adopted by the WHO-EMRO “as a main source for Member States to make use of in developing their legislation on medical and health ethics” (World Health Organization – Eastern Mediterranean Regional Offices [WHO-EMRO], 2005). This second Code also dealt with the medical profession, but as one of three themes in a larger publication dealing with a larger field of medicine and technology. The ethical guidelines concerning Muslim medical practitioners could thus be read in the light of ethics concerning advances within biology and medical technology (El-Gendi, 2005, pp. 23-

² The Codes and their respective Conferences, along with the Proceedings are referred to in short-hand forms due to practical limitations.

25).

According to Al-Awadi, the modern context of rapid developments within science and medicine made updating Islamic medical ethics necessary:

“[...] unfortunately, scientific research has lately been heading areas that could turn out to be disastrous to mankind. It has become essential, therefore, to map out the framework within which researchers may work freely without fear of transcending man’s safety and sacred rights. In short, research procedures should be considered from an ethical perspective.” (Al-Awadi, *The International Islamic Code for Medical and Health Ethics: FOREWORD*)

Contemporary modern contexts are central themes in the discussions of the IOMS surrounding Islamic medical ethics. These discussions highlight how traditional forms of Islamic authority are expressed within the frames of globalized technology and information.

When reforms of both doctrinal and social nature arise within Islamic tradition, the role of text versus context becomes one of the deciding factors when establishing religious ethics (Zaman, 2012). Likewise, themes concerning the development of Islamic medical ethics bring up the question of where authority over the label “Islamic” lies (Ghaly, 2010). On what authority should ethical principles be defined? Is the changing context of Muslims also changing the language of authority? These questions put into focus the power of definition of what can be called Islamic medical practice.

Context of the study: Clarification of terms

First of all, this study bases itself on the perspectives of the IOMS. Terms are seen in a comparative view with other perspectives and definitions, but the primary meaning of the following terms are drawn from the perspective of the IOMS and on the grounds of what they deem to be “Islamic”. To be clear: This is a clarification of terms, any deeper comparative analysis of terms and concepts will be included in the main analysis.

Medical ethics and bioethics

The terms “bioethics” and “medical ethics” are the same in both Arabic and Persian (Eich, 2011). Both are labels used in conjunction with the moral frameworks surrounding the use and research of medicine and biology. Generally, “Islamic bioethics” have been casuistic, referring to the ethical practice of specific procedures or scientific developments (Eich, 2011; Atighetchi, 2007, pp. 7-10). With the development of the human genome project, and “breakthroughs” such as the cloning of Dolly the sheep, Islamic bioethics started to include a broader perspective on ethics relating to medicine. “Bioethics” refers to a broader field of biology and medicine compared to a more narrowly defined “medical ethics” (Eich, 2011).

The current study focuses on the regulations and guidelines specifically produced for “medical professionals”. Therefore, I will use the term “medical ethics” to describe the field of ethics this study revolves around. First of all, the term “medical ethics” reads as more connected to the field of medical professionals. Secondly, the “bio-“part of “bioethics” gives it a feeling of secularity³; I find it less dissonant referring to a religious “medical ethic”.

This does not mean that “bioethics” and “medical ethics” are respectively confined to casuistic or general principles. The current study will analyze ethical guidelines of medical practice, research and education ranging from specific to general in their applications.

Ethical guidelines concerning the professionals

The main focus of this study is medical ethics meant to educate upon the moral values and to regulate the behavior of medical professionals, or “medical ethics”. A clarification of the term “medical professionals” is necessary: Dariusch Atighetchi describes the role of a doctor within the Islamic tradition to be more complex than the “clinical” definition of a doctor.

“The figure of the doctor in the history of Muslim civilization has been influenced by two complementary elements: (a) a structural element, namely the totalizing character of Islam (Islam is Religion and State) regulating all human acts. (b) The figure of the *hakim* [...] whose skills could comprise the whole of human knowledge [...] reflecting a unitary vision of knowledge, the cosmos and man, taking the absolute uniqueness of God as the point of origin. [...] the sphere of action of the Muslim doctor traditionally tends to exceed the strictly clinical context to widen out into the social and religious sphere where doctors and patients act” (Atighetchi, 2007, p. 36).

What exactly constitutes as a “doctor” in the eyes of IOMS will be examined in the main analyses. A *point of departure* concerning the terms “medical professional” and “doctor” is to include a more holistic view of the relationship between the society, religion and medicine. As a result, a professor teaching medicine could be considered a “doctor” on the grounds of teaching medicine, regardless of clinical practice.

The moral framework of the doctor is thus not only relational to the fields of technology and biology, but also to the fields of religion and society. And by relational, I mean that if changes occur within one field, it would affect the others in some way. The medical ethics are therefore not completely static unless all the relational fields are kept in status quo.

Ethics and the *sharia*

The term “ethics” is in itself heavily laden with connotations, and should be clarified in the context of this study. First of all, I use “ethics” in its most generic sense, as the normative (or regulatory) expressions of morality. To have “ethics” you need normative statements

³ I simply wish to bring less unnecessary connotations along with the main terms used in the current study.

(Brockopp & Eich, 2008, p. 57). Coming from the other side of that definition: Should a moral philosophy have specific normative statements, those are “ethics”. With regards to Islam and morality, the term introduced as the common denominator would be *sharia*, commonly defined as “Islamic Law”.

Wael Hallaq warns of the dangers underlying to identification of *sharia* with “law” or “Islamic Law”:

“[...] the very use of the word law is *a priori* problematic; to use it is to project, if not superimpose, on the legal culture of Islam notions saturated with the conceptual specificity of nation-state law [...] that, when compared to Islam's jural forms, *lacks* [...] the same determinant moral imperative. [...] In order for this expression to reflect what the Shari'a stood for and meant, we would be required to effect so many additions, omissions and qualifications that would render the term itself largely, if not entirely, useless”. (Hallaq, 2009, p. 4-5 [my underscore])

To identify *sharia* with “law” would be to reduce its function and nature to that of “just” law.

There should not be made any formal distinction between the legal and the moral, at least not in the case of *sharia*. The legal norms produced to operationalize the *sharia* should thus be viewed as the ethical regulations operationalizing the moral imperative inherent in the *sharia* as a way of life.

“Neither Muslim jurists nor Muslim intellectuals at large have – until the twentieth century – made any distinction between the legal and moral components of Islamic law. The punitive character of the obligatory and forbidden and the absence of this characteristic from the other three categories failed to engender a distinction between the moral and strictly legal [...] [B]y its very nature, Islam – both as a worldview and as an intellectual system – made no real distinction between the legal and the moral on the grounds that morality and ethics were never perceived as anything less than integral to the law”. (Hallaq, 2009, p. 85)

Normative statements made on the authority of Islam by traditional jurists have historically been treated as aspects of the underlying morality in Islam. This is reflected in the five-point-spectrum of permissibility used to distinguish components of Islamic Law: the forbidden/sinful (*haram*), the non-recommended/abominable, the neutral/permissible, the recommended, and the obligatory (*fard*/duty).

The term of “ethics” can thus be removed from any sort of *total* dependence on the Western-philosophical discussions: The concept of *sharia* both includes and represents morality as “Islamic Law”, but also as “Islamic moral imperative”. What that morality implies, and which normative statements are produced from it, depends on who interprets it and their views on what constitutes “Islam”.

Fiqh, commonly referred to as “Islamic jurisprudence”, thus attains a dual character. On the one hand there is the *fiqh* serving as *components* in the creation of ethical guidelines: the institutionalized precedence of earlier cases and “rulings”. This conception of *fiqh* may conflict with normative statements of Islamic ethics, for example if medical ethics are calling

for a more contextually based ruling than what is prescribed in the traditional works of *fiqh* (Atighetchi, 2007, p. 39).

On the other hand there is *fiqh* as a *methodology*, describing the sources and methods used to approximate the *sharia* within specific contexts. This concept refers to the sources of *fiqh* (*usul al-fiqh*) and corresponding secondary principles. Traditionally, the *usul al-fiqh* are (1) the Quran, (2) the *Sunnah* (comprised mostly of the *hadiths*, reports on the practice and saying of the prophet Muhammad), (3) *ijma* (the consensus of the Muslims)⁴, and (4) the principle of analogy, *qiyas* (Hallaq, 2009, 72 – 124).

Traditional *fiqh* has also been developed to include other “secondary” principles. Depending on the traditional allegiance of the *fuqaha* (jurists), a varying degree of importance is given to what is described as the five goals/purposes of the *sharia*, *al-maqasid al-sharia*: Life, religion, intellect, lineage and property (Gleave, 2012). When no clear solution or ruling is obvious, or in some cases possible, secondary principles of *fiqh* are invoked in order to reach the *maqasids* in a “ruling”. *Fiqh* as a methodology can therefore be understood as the method of elaborating on which Islamic grounds ethics can be legitimized, along with their applications.

Islamic Medicine (IM) and Islamic Medical Ethics (IME)

The most important factor in the concept of “Islamic Medicine” (IM) is its perspective on the history, theory and practice of medicine as pertaining to an Islamic tradition and an Islamic civilization. Based on the “point of departure” described by Atighetchi on understanding the “Islamic doctor”, we can further deduce that IM is a “holistic” approach to medicine.

In other words, IM is the practice of a specific and unique system of medicine, which is contained in or otherwise based on the teachings of Islam. In effect, this means that any medicine applicable through the teachings deemed Islamic by the IOMS can be labelled as “Islamic” medicine. Islamic medicine is therefore also a specific way (an Islamic way) of practicing medicine in general. Ethics, deemed as Islamic conduct, are thus also a part of an Islamic medical system. A last and important aspect of the IM-concept is that it is liable to change through different perspectives on its constituent elements: “Islam” and “medicine”. Examining how and why such concepts may change is part of the current study’s main analyses.

4 The relevant definition of *ijma* will be the one the IOMS may use. The point here is to identify the *usul al-fiqh* with a traditional sense of authority.

In light of the clarifications above, I have chosen to define “Islamic Medical Ethics” (IME) as the ethics prescribed in regulating the behavior of medical professionals on what is considered “Islamic” within the contexts depicted in this thesis.

Context of the study: Prerequisites to the organizations of Islamic bioethics

Reform: Colonialism and modernization

Even though Islam never had an official centralized structure of authority⁵, the *ulama* has been presented through historical studies of Islamic authority to have a certain *de facto* hegemony within the development of religiously grounded law. However, during the last century of colonial power, the Islamic system of religious education and authority underwent massive changes under European influence on society as a whole (Hallaq, 2009; Roy, 2004, p. 158). The close-knit bond between the Islamic courts and their local communities was cut, and an earlier inherent focus on contextual knowledge was removed from the requirements of several roles within the ranks of the *ulama*. This transmutation has been described as “reform”, a term that “insinuates a transition, on the one level, from the pre-modern to the modern, and on the other, from uncivilized to civilized”, and presupposes that the changes to the *ulama*’s authority were all due to colonial schemes (Hallaq, 2009, p. 3).

There are other reasons than colonial pressure which affected the *ulama* in terms of religious authority. Increasing levels of literacy and availability of the literal sources of Islam led to increasing levels of interest in the fields of knowledge the *ulama* used to have monopoly on (Roy, 2004, pp. 158-164). Another type of “reform” was the modernization projects during the 19th century by rulers such as Muhammad Ali, in which few political and intellectual actors were produced of the *ulama*. Together, all these factors instigated a differentiation between secular and religious knowledge. As the religious studies were cut off from literature and philosophy (and mathematics, etc.), the modern intellectuals were drafted from the ranks of those with “modern” scientific education (Roy, 2004, pp. 158-159).

Isolating religion as a specific discipline led to a curriculum that was unable to provide students with much needed contextual knowledge, should they be counted as relevant within modernizing societies. The *ulama* at the end of the colonial period mid-1900's had a very limited base of knowledge compared to earlier history, when complementary knowledge was acknowledged as central to the application of religious teachings.

5 Not since the death of the prophet Muhammad, at least. Arguably, the Rashidun caliphate and the early political entities of the Islamic caliphates may have come close. Historical happenings like the *mihna* of al-Ma'mun, however, testifies to the fact that power and authority within Islam was fractured from an early stage (Nawas, 1994).

Collectivist trend: The international organizations of Islamic learning

To combat the stagnation within the Islamic scholarship, and to provide answers to the growing challenges presented by modern developments of technology and information, a collectivist trend was instituted. During the late 1970's,

“[...] several international institutions of Islamic learning were established: two Islamic Fiqh Academies (IFAs) [...] and the Islamic Organization of Medical Sciences (IOMS [...]) [...]. The IOMS works exclusively on medical issues, while the two IFAs, founded to respond to challenges of the modern world in light of the Islamic heritage, also cover, inter alia, political issues and theological doctrine. [...] The legally nonbinding statements issued by these international institutions influence the shape and agenda of bioethical discussion and documents on the national level [...]” (Eich, 2011).

In essence, these councils of “collective *ijtihad*” (collective legal reasoning) were made to compensate for some central short-comings the above-mentioned historical development had brought with it. In these collective bodies, the *ulama* gather across the field of law-schools together with experts of the “secular” sciences (Atighetchi, 2007, p. 8). As with the trend from the 1800's discussed above, with the massive leaps of technological, social, political and financial developments, the basic curriculum of *ulama* could not keep up: The non-*ulama* contribute with several fields of complementary knowledge.

With regards to their authority, the organizations have two main purposes. The first is to produce recommendations/resolutions⁶ collectively between physicians, scientists and religious scholars on bioethical challenges. These statements can then be challenged and modified by other legal-ethical bodies⁷ (Atighetchi, 2007, p. 8; Eich, 2011). However, the second purpose is to outline a more univocal position, and create a stronger normative statement than individual *fukah*a could (Atighetchi, 2007, p. 9).

”Whereas during the 1980s it was not uncommon for final recommendations or resolutions of the IOMS or IFAs to document dissenting views expressed at the respective conferences, this practice was later abandoned” (Eich, 2011). This development resulted in the organizations presenting more monolithic images of “Islam”, used to legitimize statements as more normative towards Muslims and more apologetic towards critics. Nevertheless, the pluralism within interpreting “Islam” is not gone, but represented as lessened.

Islamic Organization for Medical Science

The IOMS emerged as an organization during the early 1980's, most of all as a product of the

⁶ The difference between resolutions and recommendations is that the former has a prescriptive value and the authority of the recommendation would thus be more dependent on the authority of the institution issuing it (Atighetchi, 2007, p. 8).

⁷ The contested nature of Islamic religious authority is further explained in chapter 2 on the current study's theoretical paradigm.

First International Conference of Islamic Medicine in Kuwait, 1981. The organization was officially established by decree of the Kuwaiti Amir in 1984 with Al-Awadi, Kuwait's Minister of Health, as its president (Al-Awadi, *A Synopsis of the Islamic Organization for Medical Sciences*).

According to the IOMS' website, their purposes are many: To gather historical sources of IM, revive them through scientific re-readings and apply them within education and science; to research IM and produce ethics of medical findings and professional behavior; to co-operate with international bodies within the same fields as the IOMS, and; to co-ordinate health services within the "Islamic world" (Islamic Organization for Medical Sciences [IOMS], *Decree for the Constitution of the Islamic Organization for Medical Sciences*).

The organizational structure is split into three: The Board of Trustees, the Executive Committee and the General Secretariat. All roles within the organization may be renewed more than once, making it possible to keep the structure static for as long as wanted/needed.

The Board of Trustees is the legislative organ within the IOMS, taking the decisions necessary in order for the IOMS to attain its goals and purpose. It is run by the IOMS President who also represents the IOMS in dealing with other international organizations. The Executive Committee is formed by a sub-group of the Board, consisting of its President and three other board members. Its purpose is to follow up on the work and decisions of the Board.

The General Secretariat is the actual executive branch of the IOMS, formed by a Secretary General, an assistant, as well as any number of experts, specialists and staff deemed necessary for the work of IOMS. Among its tasks are implementing the resolutions of the Board within the organization, sending invitations and preparing the draft budget (IOMS, *IOMS Membership and Machinery*).

The IOMS also runs the Islamic Center for Medical Science, a large estate-complex donated to the organization by Yousouf Al-Marzouk (a Kuwaiti entrepreneur) and his wife Lulwa Al-Nassar. It includes a mosque, the offices of the IOMS, a medical center, a drugs research department and a drug manufacturing department (IOMS, *Centre for Yousouf al Marzouk & his wife Lulwa Al Nassar for Islamic Sciences*).

In addition, the IOMS also has its own website where their publications can be ordered. The website also links to many of the IOMS' recommendations, important texts vital for conferences, and a wide array of articles and documents containing the views of the IOMS (IOMS, *Homepage*: <http://islamset.net/ioms/index.html>).

Materials of the study

The Islamic Code of Medical Ethics, 1981

The first document to be used as the main material of this study is the *Islamic Code of Medical Ethics*. The full publication of the Proceedings of the Conference of '81 in English measures some 790 pages. The actual code is included on page 731 to page 751, measuring 20 pages out of 790. The code can be read as a document on its own, but it was produced and published in conjunction with the Conference of '81 and included in the Proceedings. As such, the rest of the papers and discussions presented at the Conference of '81 contextualize the contents of the Code (El-Gendi, Hassan & Kidwai, 1981).

The Code of '81 itself contains guidelines to an Islamic, ethical practice of medicine, as pertaining to the relevant definition of “medicine” and “Islamic”. As stated, such definitions as given in this introductory chapter are points of departure; a part of this study is to examine how and why such definitions change. Most of the information pertaining to the materials is therefore given in their respective analyses, due to the nature of the current study, and the practical limitations on the size of this thesis.

The Conference of '81 gathered scholars of history and *fiqh*, as well as practitioners within different medical fields, both traditional and modern. That same year the proceedings of the conference was published in both Arabic and English, for the purpose of further study, by Kuwait's Ministry of Public Health and the National Council for Culture, Arts and Letters (El-Gendi, Hassan & Kidwai, 1981, pp. i, 16-18).

The papers presented or otherwise included in the Proceedings of the Conference were chosen to cover three main themes: (1) The history of Islamic medical heritage; (2) the application of scientific studies on treatments and procedures found within the Islamic sources and the heritage of Muslim physicians, and; (3) the principles and ethics of medical practice in relation to Islamic teachings (Al-Awadi, 1981, p. 13).

The last theme is the one the current study is focusing on. It branches out to include sub-topics such as guidance on how a doctor should behave in both his private and professional life, relationships between doctors, the relationship between a medical practitioner and his patient and principles on manufacturing drugs. However, all three main themes (1) through (3) (above) surround the central questions of the Conference: What is Islamic medicine? And: How do we revive it in modern times (Al-Awadi, 1981)? The presentations of ethical principles are interdependent with the other themes presented and discussed, both historical and clinical, and the main material in the Code is interrelated with

the whole Conference.

At the end of the conference a draft of the *Islamic Code of Medical Ethics* was presented and approved. The Code was meant to be step in the larger plan of reviving and strengthening the principles of Islamic medicine. Nevertheless, it was not produced as a *fatwa* or a manual of *fiqh* on medicine, but more in the tone of a recommendation (*tawsiya*), or a text of moral guidance, *akhlaq*. The text reads as a general guidance to the ethical practice of medicine in the light of Islamic teachings. Compared to the *fatwa*, this genre is not inherent of the same traditional religious authority in itself, and is open to a larger degree of revision through further research and developments, instead of the technical contestations between *fuqaha* characteristic of traditional *sunni* authority (Atighetchi, 2007, pp. 7-9; Eich, 2008; Kelsay, 1994, pp. 94-97).

The International Islamic Code for Medical and Health Ethics, 2004

The Conference of '04 was organized in cooperation with the organizations of WHO-EMRO, ISESCO and CIOMS⁸ specifically in order to produce the Code of '04. The three main parts of the Code, and thus the main themes of the Conference, were: (1) "Medical Behavior and Physician Rights and Duties", (2) "International Ethical guidelines for Biomedical Research Involving Human Subjects – An Islamic Perspective", and (3) "The Arguments of Islamic Law Rulings on Recent Medical Issues, Based on the Recommendations of IOMS" (El-Gendi, 2005, p. 25). The Conference comprised of religious scholars of *fiqh*, medical professionals and applied ethicist, which were all tasked with collectively producing the Code (El-Gendi, *The International Islamic Code for Medical and Health Ethics: INTRODUCTION*).

The final publication of the Code of '04 was formed as a result of the drafts, discussions and comments on the three main themes before and during the Conference of '04. Compared to the Code of '81 it is more detailed in the norms prescribed, and the "tradition"-based arguments for the implementation of those norms have been given more or less half the space of the text. Its *form* has been developed further since the Code of '81, and the textual body is larger.

The contents of the Code have also been developed. As it is presented to the reader in the context of cooperation with other international organizations, the changes will be examined in light of that cooperation. The Code of '04 will therefore be examined as an item

⁸ The Ajman University of Science and Technology Network was a last main partner of the cooperation, but its significance is never emphasized or its role pointed out within the Code of '04 (Al-Awadi, *The International Islamic Code for Medical and Health Ethics*).

of comparison to the Code of '81, in addition to being a product of it.

The additional themes of research on human subjects and developing issues within bioethics have enlarged both the scope and the specificity of IOMS' perspective on bioethics. The current study will nonetheless focus on the first theme, the ethics of the medical practitioner, as the main material to be used in analyses and comparison between the two main materials. The role of the doctor in relation to society and humanity at large is proven to be a constant factor through the central role it received at both Conferences and in both Codes. The role and ethics of the medical practitioner is therefore chosen as the object for comparison between the two Codes of IME. Whether the ethics *contained within* that role has been constant is however a part of the current study's analyses.

Introductory remarks on theory and method

The purpose of the study

The purpose of the current study is to analyze the construction of the authority within the two Codes of IME: I intend to clarify the relation between traditional, *sunni*-Islamic doctrine and the context of producing medical ethics pertaining to contemporary developments within medicine and technology. Defining the interplay between these two elements will emphasize how the different claims to authority within the Codes are constructed based on their contemporary contexts.

Method and methodology

The materials of the current study are texts. However, the purpose of this study is not *necessarily* to use philological methods of re-construct the texts' original form or identify their actual meaning (Thomassen, 2006, p. 72). The purpose is to analyze by critical perspective how the texts construct their *authority* in relation to their context, thus de-centralizing the actual texts and defining them as a product of its surroundings as well as its "authors". It is the *production* of perspectives and authority, rather than the perspective *of* the believer, which is in focus (Olsen, 2006, p. 54). As such, I find the critical tools pertaining to the method of discourse analysis most relevant for the current study.

The concept of "discourse analysis" includes theoretical and methodological perspectives on the object of study, as it is based in the social constructivist paradigm: Our world, or "reality", is based upon representations of discourses, and these discourses are constructed through the production of meaning and the different ways of understanding it.

Discourse analyses are therefore the study of the different permutations of “reality” which occur due to different understanding and production of meaning, or in the current study: authority. In the study of religious authority, discourse analysis takes the shape of a method which criticizes essentialist understandings of religious concepts and actors. When treated as discourses, these concepts and actors are understood in a specific way on the basis of their *representations* (Olsen, 2006; Neumann, 2001).

Theory

Using discourse analysis and immersing the materials within the social constructivist paradigm, means that the current study takes an active and critical role towards how “reality” appears. The theory of this thesis will take part in this by showing *how* the analyses must relate to such an appearance of “reality”.

When defining the discourses to be analyzed, the current study is based on Bruce Lincoln’s theory on discursive authority in *Authority: Construction and Corrosion* (1994): His communicational model based upon a speaker and his/her message relating to an audience within their common context is the foundation for how the discourses in my study are understood. By reading social interactions as texts within a context, the discourse analyses of an inter-textual material (such as in my own study) imply that authority must relate to the inter-discursive flux between speaker, audience and context. As such, discursive authority includes the notion of different claims to authority carrying different worth based upon the understanding of them within different contexts.

Many of the analytical models on discourses are based on media or politics (Neumann, 2001; Olsen, 2006). The current study, however, needs to define the social relations of authority within a context *religion*. Similar to Lincoln, Max Weber theorizes on the fact that authority is defined both ways between a speaker’s message and his/her audience, thus influencing each other (Parsons, 1993, pp. xiv – xvii). In order to emphasize the hegemony within the power of influencing or defining authority, the discourse analysis must highlight the different patterns emerging within the discursive elements. By using Weber I will identify such patterns as pertaining to “tradition” and its relation with the context of communicating such tradition.

The theories of Lincoln and Weber will further be operationalized. First of all, this includes the definition of “tradition” used in the current study. Secondly, I will place the above-mentioned theory within the study of Muhammad Qasim Zaman, defining the relevant *sunni*-Islamic authority as “internal criticism” and “reform”. Religious authority and

contestation are viewed as being relational to their contexts and environments. Zaman bases his theory on how traditional *ulama* are maintaining and developing the *language* of authority as a part of the reformist discourses within the ranks of traditional *sunni-ulama* (Zaman, 2012). Atighetchi (2007, p. 23) points out that modernity is forced upon bioethics through the process of globalization: On an instrumental level, bioethics are relating to medical technology, and different practices of handling patient information, as “cultural artefacts”. In my own study I have chosen to focus less on models of colonialism and post-colonialism in favor of the perspective of Zaman: To see the reformative critique within traditional Islamic authority on the basis of modernity through globalization.

Thesis statement

To paraphrase several of the speakers at the Conference of ‘81: When leading humanity, one should first of all have somewhere to go; Islam is the perfect solution in providing such an ethical stance, being focused on the role of man in God’s creation, including a needed spiritual dimension in the definition of health and mankind (El-Gendi, Hassan & Kidwai, 1981). The rhetoric of specifically *Islamic* medical ethics can thus reveal any inherent definitions of what is “Islamic”, as well as underlying attitudes towards perceived “non-Islamic” ethics of medicine.

With the basic introduction of the study given thus far in mind, I wish to analyze the two Codes of IME and their respective contexts on the basis of the following question:
How is the authority of the two Codes of IME constructed with regards to traditional Islamic authority and the context of medical ethics?

The following questions are to elucidate upon the main question of the statement of the current thesis:

Who takes part in influencing and producing the Codes?

How is traditional authority represented in the Codes and their contexts?

How are the contexts of medical ethics represented?

Further delimitations

I do not possess the vast knowledge of *fiqh* and Islamic theology of an *alim* (traditional scholar). As a result, the current study does not include comparing the contents of the Codes and their contexts to works of *fiqh*, *hadiths* or historical Islamic scholars in general. Such

ambitions would be far outside the range of my capabilities. The analyses do however include examining how the Codes are *legitimized* through the use of references to works of Islamic tradition in relation to the audience receiving them.

Other concepts, such as “modernity” and “tradition”, warrant a longer clarification, being part of the underlying theoretical paradigms used in the main analyses. They will be given a more in-depth clarification in chapter 2 on theory. Other generic terms (“the West”, “modern [...]”) will be defined in their context of use within the text of my thesis.

The structure of this thesis

In this introduction I have presented the background, theoretical basis and the context of the current study. Chapter 2 will further elucidate upon defining the discourses to be analyzed, the tools of identifying claims to religious authority and the definitions of “tradition” and “Islamic, religious authority” relevant to the current study.

Chapter 3 will highlight and explain methodological stipulations and considerations concerning the discourses defined by my representation of the materials. This will include an account of how I obtained the materials and the challenges brought to the study when using sources from the internet. The chapter both starts and ends with remarks on the methodology of discourse analyses. These remarks include a discussion on the (un-)availability of discursive elements due to reflexive and contextual factors, thus also pointing out possible complementary studies.

In chapter 4 I follow the analytical model defined in chapter 2 in order to analyze the Code of '81 and its context in line with the analytical model of chapter 2. Chapter 5 again returns to the analytical model of chapter 2, this time in order to analyze the Code of '04 and its context. In addition, the discursive patterns found within the 2004-analysis are continually compared to those found within the 1981-analysis, in order to emphasize and explain the changes within the constructions of the Codes.

Chapter 6 functions as a concluding chapter in which I discuss the conclusions reached in chapter 4 and 5 in light of each other and of chapter 2 and 3. This summarizes the study and concludes with an overview of the construction of the authority within the two Codes. The overview is consequently used to link this thesis' findings with the larger field of studying IME and the IOMS, as well as pointing out further possible complementary studies not yet mentioned.

Chapter 2: Theoretical groundwork

The context of bioethics has defined new challenges to Islamic ethical authority and its construction. Therefore I will in this chapter define and clarify the theoretical concepts and analytical tools to be used within the current study's two main analyses. By doing so, I will highlight the important elements to the analysis of the constructions of authority within and surrounding the two published codes of medical ethics by the IOMS.

The first part of this chapter concerns the concept of "authority" in general, and its construction. The concept of authority relevant to my own study is found within the theory of Bruce Lincoln, who describes authority as relational and discursive (1994). By using Lincoln as a starting point, I am laying down the groundwork for a theoretical paradigm that relies on the simplest elements of communication: a speaker, an audience, and the context of the communication between them. In addition to Lincoln's theory I will also refer to the general theories of Michel Foucault, in order to emphasize the role of contextualizing the speaker, his message and audience in the analysis of discursive authority.

In the second part of this chapter, I will use Lincoln's theory in the context of *religious* authority, as described by the theory of Max Weber (1991). This part will focus on the roles of the Weberian idealtypes of Priest and Prophet, representing the twin forces of "tradition" and "change" used to legitimize claims to authority. By introducing these idealtypes to the theories of Lincoln and Foucault, they are used to conceptualize the different types of claims to religious authority present in the construction and development of religious teachings when they are continually faced with new contexts.

The third part of this chapter deals with operationalizing the analytical tools from (mainly) Lincoln and Weber into the context of the current study, and its relevant concepts of "tradition" and "religious authority". The concept of "tradition" will be explained through the theories of Alasdair MacIntyre and William A. Graham, together creating the image of "tradition" as a dynamic concept dependent on contestation, critique by both internal and external actors, in order to exist and develop (1988; 1993). "Religious authority" will be described through Muhammad Qasim Zaman's theory on *traditional Islamic authority and reform* (2012, pp. 1-4). The definitions of "tradition" and "religious authority" presented both build upon the processes of "internal criticism" and conflict. It is through these components the analytical model will be operationalized and shown to be relevant in the current study.

Relational authority: Speaker, audience and context

The key concepts used by Bruce Lincoln in conceptualizing authority are “speaker”, “audience” and their common context of communication (Lincoln, 1994, pp. 1 – 13).

Lincoln’s theory starts with the historical roots of “authority” which he derives from Roman law and the process of *mancipatio*: the ritualized sale of land, livestock and slaves (Lincoln, 1994, p. 3). The key process of *mancipatio* was the formal and public dissolving of one person’s claim, and the public construction of another’s: In order for the *mancipatio* to be complete, five roman citizens had to witness the transaction in order for the seller to validly guarantee for the goods. The authority of the seller, the *auctoritas venditoris*, can therefore be described as the “capacity to make a consequential pronouncement” in front of the witnesses, but dependent on the *context of mancipatio* (Lincoln, 1994, p. 3).

Since the speaker of the *mancipatio*-situation is dependent on the presence of a specific audience and their witness of the process in order for his guarantee to be valid, the context and the audience have a *power of definition* over what kind of authority the seller has, and how much of it. The authority shown by the seller is highly relational to both context and his audience; the speaker must adapt to the relevant context and his audience in order to produce the type of speech that exerts his authority. As a result, the audience recognizes his authority, showing that the three components of speaker, audience and context are highly interrelated and –dependent. This relationship of dependency constitutes the relational and discursive natures of the “authority” of Lincoln. I will now turn to what the recognition of authority means and the finer mechanisms of the relation between speaker, his audience and the context of his exertion of authority.

This study is centered on a discursive definition of authority which reflects the theory of Michel Foucault of authority being ever-shifting and always involving different forms of *resistance* (Carrette, 2010, p. 284). Lincoln himself states that when writing on authority he uses the works of Foucault which does not necessarily have “authority” as their prime focus, because they “[...] treat authority as an aspect of discourse and are more attentive to its labile dynamics than to its institutional incarnations” (Lincoln, 1994, p. 2).

The relational nature of discursive authority implies a difference between *having* authority (over someone) and *being* an authority, like the bearer of a title such as Professor or Prime Minister (Lincoln, 1994, pp. 3-5). Lincoln states that executive authority, to *have* authority, is an effect that

“[...] does not arise out of some quality of the speaker, such as an office or a charisma. Rather, [Lincoln believes] it is best understood in relational terms as the effect of a posited, perceived, or institutionally ascribed asymmetry between speaker and audience that permits certain speakers to command not just

the attention but the confidence, respect, and trust of their audience, or – an important proviso – to make audiences act *as if* this were so” (Lincoln, 1994, p. 4).

Having or exerting authority over someone relies on an asymmetry between the speaker and the audience. Thus, the basic element of authority encountering discursive resistance is that authority relies on an agreement that it exists. In order for the asymmetry to occur, the speaker needs (1) an audience that (2) recognizes and acknowledges the asymmetry, based on (3) the context of communicating authority.

The centrality of the audience is further enhanced by the relational nature of discursive authority, which Lincoln perceives as “[...] (1) an effect; (2) the capacity for producing that effect; and (3) the commonly shared opinion that a given actor has the capacity for producing that effect [...]” (Lincoln, 1994, pp. 10 – 11). The asymmetry thus needs *a legitimizing factor or reason* in order to occur, or to be perceived as having occurred. Consequently, the difference between *being* an authority and *having* authority is that the latter is only in relation to an audience, emphasized by the fact that “[in] actual practice the exercise of authority depends less upon the ‘capacity for reasoned elaboration’ as on the *presumption* made by those subject to authority that such a capacity exists, or on their calculated and strategic willingness to pretend they so presume” (Lincoln, 1994, p. 5).

The context of communication can be viewed as the stage of the speaker, which presents the speaker with the possible options for legitimizing his message. The message’s status of legitimate or not depends on the audience and their ability, or willingness, to acknowledge the asymmetry between them and the speaker. Discursive authority is therefore defined as

“[...]the result of the conjuncture of the right speaker, the right speech and delivery, the right staging and props, the right time and place, and an audience whose historically and culturally conditioned expectations establish the parameters of what is judged “right” in all these instances” (Lincoln, 1994, p. 11)

As the message of the speaker (incorporating the legitimizing factor with regards to its audience) becomes victim to the hermeneutical circle, the speaker’s authority takes on a discursive nature: The context of the speaker shapes his message and his claim to authority, which is then posited onto the stage. The subject of the audience relates to a context of its own, which shapes the audience’s *understanding* of the speaker’s message and claims to authority. As a result, discursive authority lies not in its claim alone; it is not enough just *being* an authority. For a speaker to *have* authority he is dependent on the subjective interpretation of his message by the audience to be accepted or acknowledged as such.

Due to the high level of interdependence between speaker, the audience and their common context, the acceptance of the speaker’s authority relies on both the audience’s

understanding of the stage and the speaker's message. Thus, the construction of the speaker's authority includes and transcends the hermeneutical circle: It constitutes a discourse of its own which includes the power of the audience and the stage over the speaker and his message.

To represent the speaker's authority including and depending on its contextual elements, the discourse of authority is from here on referred to as the Speaker. This means that the person of the "author"⁹ of the Speaker's message is decentralized as its authority is considered a product of both him/her and the elements of his/her context: the Speaker is crystallization of the claims to authority within its message, shaped by its context and audience. It is the aim of the current study to analyze the construction of a Speaker and its message.

Religious authority: Weber

In order to illustrate the nature of religious authority and the construction of such, I turn to Max Weber and the use of the idealtypes¹⁰ "Priest" and "Prophet"¹¹. These two are first of all used to exemplify how religious authority is legitimized by either tradition or change.

However, Weber was concerned with the process of rationalization in the development of cultural traditions (Parsons, 1993, p. xiv).

"Rationalization increases the inner coherence of religious beliefs and thereby creates new, distinctly religious dilemmas. [...] The more rationalized a religious world view, the deeper and more pressing contradictions it creates, and the stronger the impulse for religious innovation. [...] For Weber, rationalization gives ideas their power, because rationalization intensifies and deepens the meaning of inherently non-rational, and ultimately *non-rationalizable*, aspects of human experience." (Parsons, 1993, p. xv).

Weber theorized on internal rationalizations, when the teachings of a religious tradition need to fulfill the requirement of having a complete and coherent world view. Thus when meeting new elements which do not fit into its world view (made complete and coherent in relation to its already existing teachings), rationalized religion contradicts with the reality experienced by its laity. The stronger these contradictions get, the stronger the perceived need for change becomes. Religious innovations are thus set in motion in order to achieve an even more coherent world view¹², thus developing the scope and size of the tradition. As representing tradition and change, the idealtypes of Priest and Prophet are therefore central to the concept of rationalization and subsequent developments of religious teaching and practice.

⁹ The "author" refers to a *person* or institution within the Speaker responsible for creating the actual message of claiming authority, for example the seller within the *mancipatio*-ritual.

¹⁰ I consider the Weberian "idealtypes" to be a well-known tool within the study of religion.

¹¹ The third archetypical idealtypes of the "magician" has been left out due to not being considered as useful within the concept of "religious authority" of the current study.

¹² For example: the introduction of Original Sin to explain why evil exists in a (thus far taught) world ruled by an omnipotent and wholly good God (Parsons, 1993, p. xv).

In a Weberian sense, the Priest is a character of religious authority who is legitimized through the office he inhabits and represents. As such, he has a traditional and institutional authority. In the case of the Priest, he qualifies as *being* an authority through status. *Having* authority as a Priest still requires an audience he can act as a Speaker towards: in order to claim Priestly authority, the Priest has to behave according to the image of a Priest in order for his audience to acknowledge his function and office, and thus his authority. As such, he is an official of religion (Tybjerg, 1993, p. 150). Central to the idealtypical concept of the Priest is the notion of historical continuity.

The Prophet is a charismatic, for example with “a calling” directly from the highest legitimizing figure of authority within a religion which he receives and conveys a message from. His own authority thus rests solely on his audience, and as such the Prophet represents a purely personal role of authority which is the opposite to that of the Priest: being “independent”¹³ of any former religious tradition, the Prophet can only be regarded as *having* authority if his message is accepted or acknowledged as real by his audience.

Weber calls the legitimizing factor behind these two roles of authority for *charisma*: a religious effect or skill which characterizes “the chosen” or elevated people and objects within a religion (Weber, 1991, p. 2). It is a characteristic which legitimizes the idealtypes in the eyes of their audiences, containing an effect which lies outside the realms of normal human action and behavior: The Prophet has a calling and preaches a religious message, and the Priest has charisma based on his office through a religious institution, organization or order (Weber, 1991, pp. 46-47).

Using the concepts from the theory of Lincoln the religious authority of the Priest and Prophet is defined by the interdependence of speaker and audience when asserting and exerting authority. The key to this interdependence lies in the concept of “charisma” which translates into the legitimizing factor of the asymmetry between a Speaker and its audience. The *person* of the Priest or Prophet is thus decentralized, reconstituting “charisma” as the legitimizing factor belonging to an ideatype and not (necessarily) an actual characteristic of the person acting as Priest/Prophet¹⁴.

What this means is that the Priest *represents* (to varying degrees, being an ideatype)

¹³ That is, independent of tradition in its ideal form; in practice Prophetic authority is indeed based upon former tradition, if only as a reaction to it.

¹⁴ Still, Lincoln’s “asymmetry” is stated to be “posited, perceived or institutionally ascribed” (Lincoln, 1994, p. 4) leaving personal charisma (in its common definition) and traditional institutions by no means powerless within the theoretical paradigm of this study.

the perception of a historical continuity (tradition) within religious authority. Likewise, the Prophet *represents* change and innovation in the face of perceived contradictions between religious “truth” and the reality of the laity. This conceptualization of the Weberian idealtypes means that the same person can act as both Priest and Prophet when claiming religious authority. Nonetheless, acting as Priest and Prophet is based on an audience acknowledging those claims:

“Prophets and priests are the twin bearers of the systematization and rationalization of religious ethics. But there is a third significant factor of importance in determining the evolution of religious ethics: the laity, whom prophets and priests seek to influence in an ethical direction” (Weber, 1991, p. 45).

The mechanism of rationalization can also be explained within the theory of Lincoln’s Speaker, audience and context. There is a tension between the two idealtypes of Priest and Prophet which reflects the relation between tradition and change. The Priest has an authority based on the legitimizing factor of tradition, creating an immediate trust in him as a figure of leadership in relation to his audience (Tybjerg, 1993, p. 152). The Priestly element is the point of departure for a period of innovation and further rationalization as the context of the audience (the laity) comes into conflict with the context of the Speaker (the current religious teachings). In order for the Speaker to maintain authority, its message must be acknowledged by the audience. In order for that to happen, the message of the Speaker must relate to the growing contradiction towards the laity.

This is where the Prophetic element comes in. The structures of tradition and authority that surrounds the Priest are switched out with a complete dependency on the audience and the precarious nature of *their perception of the Prophet*. The role of the Prophet is revolutionary, and distanced to past tradition in favor of the reality of the laity¹⁵. Change and religious innovation are the key processes legitimizing the Prophetic element. Its authority in creating new religious realities is also short-lived, in reality only existing in phases of *schisms or breakthroughs* (Tybjerg, 1993, pp. 151-152). The Prophet is thus the element of *reform*.

According to Weber’s theories the Prophetic message is made rational within the religion’s teachings due to its original alien nature. Consequently, the Prophetic elements are incorporated into the religious tradition. This in turn legitimizes the authority of the Priest through his office in the institution of the earlier Prophetic message, constituting the theory on “the routinizing” of Prophetic charisma

Through rationalization the Prophetic charisma is made part of the established structures of power, thus constructing the authority of the Priest in relation to the laity. By

¹⁵ Prophetic elements might also seek to change the laity’s reality, and can as such also be alien to the practical reality of everyday life.

specifying the general concept of “authority” to that of “religious authority”, and applying the theories of Weber, my hypothesis is specified to include that the context is what forces the speaker to adapt to the audience, thus revolutionizing his message (or innovating tradition) in order to maintain relevance, and thus authority. This in turn emphasizes the role of the context within the structure of the Speaker, and the importance of contextualizing the Speaker’s message when analyzing its construction of authority.

Islamic religious authority: Zaman

Lincoln’s defined the general concept of “authority” as a product of discourse. Consequently, authority needs to be analyzed within the context of communication, or discursive “stage”, where authority is relational to the audience. By using the theory of Lincoln, I have decentralized the specific institutions and persons of the idealtypes Priest and Prophet. The reason for this is to explain how claimants to religious authority need to react to their audience and stage, and therefore to varying degrees legitimize their claims through tradition and change.

This last main part of the chapter concerns the conceptions of “Islamic religious authority” and “tradition”. Muhammad Qasim Zaman identifies issues of Islamic religious authority through three interrelated considerations: (1) The disjunction between imagined authority and authority in practice; (2) the nature of religious authority as a matter of “unrelenting contestation”, an authority on ever-shifting grounds and always under pressure, and; (3) the context’s power of definition on any claims to authority (Zaman, 2012, pp. 30-33). In order to operationalize the analytical tools defined thus far (Speaker, Priest and Prophet) within the paradigm of Zaman I will explain the rationale behind his “three considerations” (above), starting with the first: the disjunction between imagined authority and authority in practice.

To study *Islamic* authority is to refer to an institution of authority, regardless of how loosely defined such an “institution” may be. Zaman defines religious authority simply as “[...] to mean the aspiration, effort, and ability to shape people’s belief and practice on recognizably ‘religious’ grounds” (Zaman, 2012, p. 29). What is deemed as “religious grounds”, the “institution” of the relevant authority, is “[...] on grounds that [the Speaker] and [its] putative audience would consider ‘religious’” (Zaman, 2012, p. 29 n. 112). Zaman is referring to Talal Asad’s assertion that the identification of “religion” and anything labeled “religious” is a

matter of discourse, and a highly relational concept (Zaman, 2012, p. 29 n. 112):

“It is part of my basic argument that socially identifiable forms, preconditions, and effects of what was regarded as religion in the medieval Christian epoch were quite different from those so considered in modern society. [...] There were different ways in which it created and worked through legal institutions, different selves that it shaped and responded to, and different categories of knowledge which it authorized and made available. [...] My argument is that there cannot be a universal definition of religion, not only because its constituent elements and relationships are historically specific, but because that definition is itself the historical product of discursive processes” (Asad, 1993, p. 29)

The key elements needed to ascertain what counts as religious authority and how it works are all relational seeing as the definitions of both “religious” and “authority” are products of discursive processes. Even though it may be conceptualized as an institution of authority, Islam and Islamic authority is thus still dependent on the relation between Speaker and audience (as described in Lincoln’s theory) when producing normative statements.

Explained with the concepts of Lincoln, authority may be *imagined* to imbibe the speaker with control over his audience, or that “[...] it should be able to have people take particular paths to the exclusion of others, *despite* their own reasons for acting differently” (Zaman, 2012, p. 30). What characterizes Islamic authority in practice, however, is that it is questioned by the audience, and furthermore, often *recognized as being questioned*. A classic example of this within the sphere of traditional Islamic authority is the non-binding nature of the *fatwa*, and the possibility for the laity to seek other legal opinions and alternatives should a *mufti* produce a statement not fitting their agenda (Zaman, 2012, pp. 30-31). This can be seen, if we apply both Weber’s and Lincoln’s concepts, as a case of the Speaker relating to the audience in order to have authority, the Priestly claim to authority being the Islamic institution of the *fatwa*. The Prophetic claims to authority in the case of the *mufti* may be regarded as to which degree he facilitates the *fatwa* to the needs (or agenda) of the laity.

Zaman’s study of Islamic authority is centered on several key questions in order to understand the different dimensions of the “reformist” debates within modern Islam (Zaman, 2012, p. 1): On what authority has reform been legitimized and built upon? What major themes have critics centered their rhetoric of reform on? And: How does the Islamic tradition function as both object of, and the grounds for, such critique? In order to explain the second and third considerations of analyzing authority within Islam it is important to notice the implications these questions carry with them regarding how we understand terms such as “reform” and “tradition”, and thus also Prophet and Priest (respectively).

Even when partially removed from the colonial and post-colonial paradigm described by Hallaq, taking care to realign any overly biased connotations to the translation of *sharia* as “The Islamic Law” (Hallaq, 2009, p. 3), “reform” is still in need of further clarification in the

context of my own study; it is both a question of *what* “reform” means and *why* Zaman uses it. The concept of reform has a broader range than the activities of either Islamic “modernists” or Islamists. The current study does not aim at labelling the IOMS as “reformist”, to be compared with “modernist” or “traditionalist”. Its aim is quite the opposite: to explain how the concepts of tradition, modernity and reform are intertwined in the construction of the type of traditionalist ethical guidelines the current study focuses on.

The groundwork of this aim has been built by explaining that the Priest- and Prophet-ideal types of religious authority are central to the development of religious tradition through rationalization and innovations, and; that they are pivotal to each other’s respective claims to authority due to the routinizing of Prophetic charisma into Priestly office. However, Priest and Prophet are extremely broad ideal types centered on the concepts of “tradition” and “change” which encompass large fields of authority. As such, it would also be wise to notice that the lines between Islamist, traditionalist and modernist religious authorities are often blurred, and should not be misrepresented by imposing reductionist demarcations or labels upon them¹⁶ (Zaman, 2012, p. 2).

The concept of reform in this study relies on traditionalist scholars; important contributors to the debate on the reform of Muslim societies *through the critique of particular aspects of the Islamic tradition*. As such, “reform” encompasses the vital part of tradition that is *internal criticism*: the act of rethinking tradition from within by the same people vested in both preserving and defending it¹⁷ (Zaman, 2012, pp. 2-3). “Reform” and “internal criticism” are thus the process within Islamic traditionalist authority where the Speaker acts as both Priest and Prophet, and contributes to the Weberian mechanisms of developing religious tradition.

Further clarification of the roles of reform and internal criticism requires giving an account of the concept of “tradition” they relate to. The point of departure to conceptualizing “tradition” as relevant to the current study is found within the following quote of the moral philosopher Alasdair MacIntyre:

“To be an adherent of a tradition is always to enact some further stage in the development of one’s tradition; to understand another tradition is to attempt to supply, in the best terms imaginatively and conceptually available to one [...] the kind of account which an adherent would give. And since within any well-developed tradition of enquiry the question of precisely how its history up to this point ought to be written is characteristically one of those questions to which different and conflicting answers may

¹⁶ For example, the paradigm of globalization has produced a dissemination of authority, which has been furthered studied to entail new types of professionalization of traditional religious roles of authorities such as the “neo”-*ulama*, which could easily fit all three labels of Islamic political thought mentioned above (Roy, 2004, pp. 148-200; Eickelman & Piscatori, 1996, pp. 38-45, 131).

¹⁷ Criticism of the religious tradition is thus not necessarily based in secularity, nor fundamentalist or “liberalist” perceptions of Islam (Zaman, 2012, pp. 2-3).

be given within the tradition, the narrative task itself generally involves participation in conflict.” (1988, p. 11)

As MacIntyre puts it, both external and internal conflict is what defines the dominant narrative of a tradition, deciding what should be counted as its historical precedents and thus defining its potential as a legitimizing factor in claims to authority. The next sub-chapter is therefore dedicated to the image of “tradition” as dynamic and ever-developing through the process of internal criticism, and the roles of conflict and reform within such a view of tradition. This will also clarify that the concepts of “tradition” and “reform” need not be dichotomous, but a symbiotic pair, as represented by the Priest/Prophet-conceptualization of rationalized tradition and authority¹⁸.

Tradition: William A. Graham and Alasdair MacIntyre

In his article on “traditionalism in Islam”, William A. Graham points out certain central aspects important to the current study’s concept of “tradition”, the first of them being that “[...] tradition cannot be relegated, even in advanced industrial societies, to the past or discarded as something opposed to, or to be superseded by, reason, innovation, technology, or science, since all of these also depend on tradition” (Graham, 1993, p. 497 [my underscore]): The nature of tradition is as a historical continuity always connected to the ever-shifting present.

This leads to the second important aspect: tradition is liable to change. Tradition may give the impression of eternity, and may indeed carry signs of rigidity. However, it has already been pointed out that central to the life of tradition lies the process of internal criticism and the conflict of defining its narrative. In addition, criticism does not have to be invoked on neither secular nor liberal grounds. This means that traditionalism does not have to be conservative: traditions can function on their own as the basis for reforms and innovations (Graham, 1993, p. 499; Zaman, 2012, p. 3).

The roles of Priests and Prophets are defined as idealtypes in order not to box in the concepts of “tradition” and “reform” and creating a biased dichotomy. To understand the Priest and Prophet as idealtypes, it is important to notice that “[just] as tradition is not the opposite of reason or innovation, traditionalism is not the opposite of modernism [...]” (Graham, 1993, p. 499). The process of internal criticism does imply a perceived demarcation between what is internal to a tradition and what external. Traditionalist authorities may thus

¹⁸ The dangers of setting up such dichotomies as “tradition” and “reform” (or “tradition” and “change” as I have earlier done with the roles of Priest and Prophet) have been commented upon by many (Graham, 1993, p. 497). The view of “tradition”/Priest and “reform”/Prophet as a symbiotic pair is a take on answering to such dangers, and the discussions of misrepresentation.

oppose what is perceived as “modernism” should it be deemed destructive towards “traditional” values in a society, or the society they wish to create (Graham, 1993, p. 499; Zaman, 2012, p. 34). However, due to the concept of “tradition” defined in the current study thus far, modernity is first of all conceptualized as the contemporary context tradition has led to, and the context it needs to deal with in order to develop further.

Graham’s “tradition” can be conceptualized on two levels: The first is the local or specific form, close to synonymous with “custom” and institutions ascribed to it, “a belief or practice transmitted from one generation to another and accepted as authoritative, or deferred to, without argument” (Graham quoting Acton, 1993, p. 496). The second level is “tradition” in a collective sense, understood as the sum of a community’s specific traditions as described on the first level (Graham, 1993, p. 496). A traditionalist in the context of the current study is thus someone who primarily relates to the historical authority of older precedents and traditions within the cumulative tradition of the community he is a member of.

The concept of tradition and religious authority presented thus far can be summarized by the following definition of “a tradition” put forth by MacIntyre:

“A tradition is an argument extended through time in which certain fundamental agreements are defined and redefined in terms of two kinds of conflict: those with critics and enemies external to the tradition who reject all or at least key parts of those fundamental agreements, and those internal, interpretative debates through which the meaning and rationale of the fundamental agreements come to be expressed and by whose progress a tradition is constituted. Such internal debates may on occasion destroy what had been the basis of common fundamental agreement, so that either a tradition divides into two or more warring components, whose adherents are transformed into external critics of each other's positions, or else the tradition loses all coherence and fails to survive.” (1988, p. 12)

Tradition is continually established by its own internal criticism, an aspect of tradition which may potentially either develop or divide it. Seeing as criticism inherently requires a conflict with whatever is being criticized, traditionalists may be in a dynamic and shifting relationship with their tradition. As reformers of tradition, the traditionalists are still loyal to what they perceive to be the core principles of that tradition: the “fundamental agreements” defined by tradition’s historical continuity as “an argument extended through time”. As Zaman puts it, we are not “[...] to suppose that a tradition’s internal critics are critical of all aspects of that tradition: they would not be *internal* critics if that were the case, for their goal typically is to defend certain aspects of that tradition by critiquing others” (Zaman, 2012, p. 34).

Tradition, internal criticism and Islamic authority

According to Zaman, internal criticism and religious authority are defined by many of the same characteristics, mainly those mentioned earlier in the introduction of Zaman’s theory on

authority (Zaman, 2012, p. 34). Religious authority, tradition and its internal critics have been shown as heavily interdependent of each other thus far: No religious tradition evolves (and lives) without internal critics claiming authority; no religious authority can be claimed without having a tradition to either base it upon or criticize, and neither can you claim the ability to criticize without engaging the authorities of a tradition thus far.

Regarding the second consideration on the nature of religious authority within Islam, Zaman states that it “is a matter of unrelenting contestation. Claims to it involve contesting other claims to it, dislodging or otherwise unsettling rivals, showing the inadequacy of existing views, and defending one’s own” (Zaman, 2012, p. 33): The process of internal criticism is central to its discursive nature. Foucault would also come to incorporate a view of power as “mobile and non-hierarchical”, which, similar to Zaman’s conception of authority, would make it hard to imagine it existing in an intellectual vacuum, i.e., without challenges to it (Carrette, 2010, p. 284; Zaman, 2012, p. 33). As Zaman puts it:

“However good contestation may be for the health and vigor of a tradition, few people would wish to confront serious challenges of their own accord. In practice, of course, they must do so, and they do this not with preemptive or exclusionary authority but with one that competes, even as it coexists with rival claims” (2012, p. 35).

The characteristics of MacIntyre’s “tradition” and Zaman’s “religious authority” are exemplified by Graham’s theory on a specifically *Islamic* type of traditionalism:

“[The] long-standing, overt predilection in diverse strands of Islamic life for recourse to previous authorities, above all the Prophet and Companions, but also later figures [...] who are perceived as having revived [...], reformed [...], or preserved [...] the vision and norms of true, pristine Islam, and thus being in continuity and connection with the original community, or *ummah*. [...] An important concomitant of this attitude is a wariness or even abhorrence of any ‘innovation’ (*bid’ah*) that runs counter to the perceived tradition.” (Graham, 1993, p. 500)

The focus on a “true, pristine Islam” and its continuity with a semi-mythological past, represented by the first *ummah*, corresponds to MacIntyre’s “fundamental agreements” within the Islamic tradition; the internal critics expressing the “meaning and rationale” of those fundamental agreements, are the “previous authorities” described in the quote from Graham. Lastly, the demarcation of internal/external is referred to by the concept of “innovation”, or *bida*. It is akin to the concept of heresy in the regard of being an internal conception which becomes, or is at least regarded as (by its critics), an external threat to the integrity of the tradition.

The third consideration that needs to be taken into account when identifying issues concerning religious authority is how *any claim to authority is dependent on its context*, repeating the presence of a discursive hermeneutical circle:

“[...] [The] meaning and scope of any such claims are necessarily tied to the specificities of their context. Even the most authoritative of a religious tradition’s texts not only constrain but are constrained

by how people will understand them in their particular contexts. [...] [Authority] is constructed and understood in accordance with the exigencies of particular circumstances” (Zaman, 2012, pp. 31-32) Zaman thus posits several similar characteristics of religious authority as those of the Weber/Lincoln-synthesis: (1) A context-based approach to authority makes it a relational concept, and; (2) “[It] is only in relation to others [...] that one can be said to *have* authority” (Zaman, 2012, p. 32). These characteristics are also central to internal criticism, which is defined and understood depending on the context it is articulated in and of the audience.

In order to understand the value and significance of a particular criticism it needs to be placed within the context of a tradition adherent. The meaning of that criticism, and its effect, is thus decided relationally. As the criticism “[...] seeks to reconfigure how different facets of the tradition relate to one another” (Zaman, 2012, p. 35), the usage of different facets of tradition to legitimize authority, along with different perceptions on how legitimizing those facets are, results in the criticism having different effects varying between contexts. Depending on the context and audience, the criticism may even be regarded as *bida*, and thus made external. Thus: “[What] makes criticism *internal* is itself a relational matter” (Zaman, 2012, p. 35).

The contested nature of Zaman’s “religious authority” and “internal criticism” functions as a recognition of their relational nature. Being contested, dependent on context and recognized as questioned and in conflict with other claims to authority as well as with earlier authorities, they are never set in stone. The centrality of internal criticism to the development of a tradition attests to the necessity of both Priestly and Prophetic claims to Islamic authority. Conflict and contestation takes form in what I have described as the rationalization of tradition in the face of new contexts meeting earlier routinized Prophetic and Priestly authority. Contestation in practice within a tradition is thus different claims to authority based on different levels of Priestly and Prophetic legitimization as reactions to the specificities of those claims: their contexts and audiences.

The paradigm of relational, discursive, Islamic authority

In this chapter I have given an account of the main analytical tools of this study, found mostly within the theories of Lincoln and Weber. The main analytical concept is that of the Speaker, and its claims to authority. Due to the relational nature of discursive authority, the Speaker’s message (and thus its authority) is a product of the Speaker’s audience and their common context of communication.

In the case of this common context being “religion” or of a religious nature, the

Speaker must legitimize its authority through Priestly and Prophetic claims, depending on the other elements of the Speaker-structure. Together, these two idealtypes are the main factors of developing and re-contextualizing religious tradition through the mechanisms of rationalization and routinizing Prophetic charisma, thus providing the Speaker with a message adapted to its audience and context.

Furthermore, the analytical tools of Speaker, Priest and Prophet have been described as fitting into the concepts “tradition” and “Islamic religious authority” of MacIntyre, Graham and Zaman. MacIntyre and Graham describe how rationalization (equated with inner criticism) is shown to be central for the life of tradition, and Zaman describes how inner criticism has been manifested through a system of contestation on authority in modern *sunni*-Islam. This constitutes the theoretical point of departure for the main analysis as it takes on the more living main material of the current study. My hypothesis is that the constructions of authority referred to within that material can be analyzed by clarifying how the Speakers of the two Codes of IME uses Priestly and Prophetic claims to authority.

In conclusion to the characteristics of the discursive, context-based and relational religious authority, we are faced with a concept of authority that “[Is] not a stable endowment but one that is always exposed to implicit or explicit challenge and that it waxes and wanes in response to the pressures bearing upon it” (Zaman, 2012, p. 33). The reason for this is that contestation is as critical to religious authority as it is to the life of the tradition itself (Zaman, 2012, p. 34). The aspect of reform within the institution of collective *ijtihad*, mixing both secular and religious scholars as seen in the field of Islamic Medical Ethics, is highlighted through identifying their claims to authority as Priestly or Prophetic.

Chapter 3: Methodological stipulations

The paradigm of social constructivism has several implications on the theory, method and materials of this study. The comparative strategies used in order to analyze the constructions of the Speaker-structures, and their claims to authority within their message of the Codes, entails a modification of “the truth” that these discourses contain. These modifications are decided by the connotations and comparisons I make with the object of study, based upon my interests as a student, and to a large degree upon which parts of the discourses are available to me. The methodological application of “comparison” must therefore be improved from its basic status of pure, cognitive tool. This is done by “correcting” my suppositions towards my object¹⁹ of study, through contextual knowledge, strategic implementations and reflexive reflections (Stausberg, 2006, pp. 35-38). The materials and how they are represented are accordingly of great importance to the current study’s value and credibility.

As a part of the post-structuralistic school of humanities and social sciences, social constructivism questions to which degree a discourse can be reconstructed in order to reveal knowledge of how *meaning* is produced, or in the case of this study, *authority*. Based on this critique, the depictions of the discourses in this thesis are treated as *constructions* dependent on my own theoretical understanding of them. My own studies, as well as the materials, are therefore subjects to hermeneutical circles, as the analyses and their conclusions are *conveyed* as “knowledge” of the discourses studied (Cavallin, 2006, p. 18). Just as Lincoln’s, Weber’s, Zaman’s, Graham’s and MacIntyre’s theories are structures dependent on the contexts of their studies and understanding, so is my own theory of the Speaker-structure. This is not to say that my object of analysis has no *value* of its own, but that its *meaning* depends on how the current study and thesis are constructed. As such, the materials are still capable of resisting my theories. I will therefore clarify the methods used in this study, and which implications they have on my conclusions.

Social constructivism, discourses and the Speaker

A central stipulation of the social constructivism is how the abovementioned *conveyance* of meaning between the abstract and the concrete material is based on which theoretical approach is used (Cavallin, 2006, p. 27): The way the discourses in the current study are depicted, and thus also the meaning derived from them, are the direct results of how I define

¹⁹ I acknowledge the subjective nature of this “object”, as per methodological requirements. However, in order not to create too many cognitive diversions within a discourse-theoretical study, I refer to the Speaker and the Codes as “objects” of study and let their complex structure speak for their subjectivity.

and shape them. This means that because theory models “reality” (as discourses) the “reality” I convey further has been constructed by my theory. As a result, theory defines its own methods (Cavallin, 2006, p. 27), and methodology becomes a large part of the applied method. In order to analyze the constructions of *authority* within discourses I have therefore chosen to model the current study upon theories of discursive authority.

I have chosen to use the “Speaker”-structure as the over-all analytical tool in order to discern the constructions and claims to authority lying within the two Codes of IME. This is mainly due to how its structure (speaker/”author”, audience, context and message), together with the Weberian idealtypes used, answers to the theories of Zaman, MacIntyre and Graham. It is also due to how the concept of “discourse” varies largely from study to study. As a result, I defined a specific concept of “discourse” as “the Speaker” and linked it to the abovementioned theories. Nevertheless, “discourse” continues to be a pluralistic concept, treated “[...] sometimes as the general domain of all statements, sometimes as an individualizable [Sic.] group of statements, and sometimes as a regulated practice that accounts for a number of statements” (Foucault quoted in Neumann, 2001, p. 17).

The Speaker-structure is a result of the over-all purpose of my study: To analyze constructions of “Islamic” authority, with a foundational thesis stating that claims to authority reflects their context and audience. The three interdependent elements within the Speaker, the ”author”, audience and context, influences its message, which is further examined to contain Priestly and Prophetic claims to authority based upon that influence. As a result, examining the Speaker-structure is as important as examining its message when analyzing its claims to authority.

This study centers on two different contexts. One Code was produced and presented in relation to a conference in 1981 and the other to a conference in 2004. The elements of the “author”, audience and context of the Speaker-structure are (to varying degrees) specific to these contexts. This in turn produces two different Speaker-constructs, a Speaker of ’81 and a Speaker of ’04, pertaining to their different messages, the Codes of ’81 and ’04. The consistent object within the current study is thus the theoretical definition of the Speaker-structure as defined in chapter 2. As the Priestly and Prophetic claims to authority are unclearly defined without knowing the contextual factors of the message within the relevant Speaker-construct, the idealtypes of Priest and Prophet are also (to varying degrees) specific to their contexts. In order to analyze the Speakers’ claims to authority, the study is therefore based on analyses of the Codes through the construction of the Speaker, and not the other way around.

By examining the Speakers' claims to authority, and categorizing them as Priestly (traditional, institutional) and Prophetic (contextual, reformatory), I temporarily freeze the oscillations of influences between the elements of the Speakers, which can then be further compared with each other. The study thus aims at producing a result relating to both the philosophy and theory pertaining to the academic study of religion, and towards the state of the study of IME and Islamic religious authority.

Main materials

Selecting the materials for this study was dependent on them being available and written in English²⁰. I do not know the Arabic language per se, only through concepts and phrases introduced to me through the years of studying Islam and Muslims, and then only when Latinized. The process of identifying and obtaining the main material consisted of cross-referencing materials published in, or translated to, English within books and articles on Islamic Bioethics, Islamic Medical Ethics and collective *ijthad*. This led me to the *Islamic Code of Medical Ethics* of 1981 as the first instance of main material. However, almost all references were to a publication of the Code on the IOMS' old website, which was closed down at an unknown time. By searching the database of the Bioethics Research Laboratory at Georgetown University (<https://bioethics.georgetown.edu/using-the-library/catalog-search/>) I discovered that the Code existed in a published form titled the *Proceedings of the First International Conference on Islamic Medicine*. By early January 2014, the IOMS' websites were re-opened on a different server, where I found the *International Islamic Code for Medical and Health Ethics* from 2004. I had earlier come across a similarly titled document on the websites of the World Health Organization, and needed to identify the details of publication of the actual Code and its printed title in order to acquire its physically printed and published volume. Through email-correspondence with the offices at CIOMS, WHO-EMRO and lastly with Dr. Muhammed Ghaly I was able to identify and obtain the last of my main materials, the physical publication of the Code of '04.

The main materials of this study pertaining to the two different Codes of IME were published as books, both in English, and both through the state of Kuwait and/or the Islamic Organization for Medical Sciences (IOMS). The '81 publication of the Proceedings of the

²⁰ This implies finding materials containing (1) the needed information for a discourse-analysis, (2) on Islamic authority within bioethics, (3) and the practice of collective reasoning within conferences and seminars, (4) in English (or Norwegian).

First International Conference on Islamic Medicine²¹ also contains most of the material on the Code's context: The papers presented and published with the Conference itself. The papers are used to represent the opinions of the "audience" within the Speaker of '81. Additional material on the Speaker of '81 includes an article reprinted in the Journal of the Islamic Medical Association (JIMA), and a number of articles published on the IOMS' websites. All of these are treated as materials presenting the subjective views of the authors.

The publication of the *International Islamic Code for Medical and Health Ethics* '04 was actually published in English in 2005²². However, in order to maintain chronology with its contextual elements, I will refer to it as the "Code of '04". The Code of '04 provides no papers, but knowledge of the Speaker of '04 through two introductions and a foreword. Both Codes are also available on the website of the IOMS. In order not to rely on fluctuating access to my main material, I have mainly relied on the published book-versions of the Codes.

Due to restricted availability on the material, I did however have to consult with the publication of the Code of '04 on the IOMS website. All such work was compared with the printed version in order to double-check for any discrepancies. In order not to confuse the references between the two versions of the Codes, I will make short-hand references to the relevant articles within the Code (both versions are structured by articles). This is also in order to take into consideration the practical impossibility of applying the whole title of the document for each article I refer to within the limited size of this thesis. The internet version is entered in the bibliography under its full title as *Part One: Medical Behavior and Physicians Rights and Duties*, and as authored by the IOMS. The references to its articles within the text of this thesis will be as (IOMS, *Part One*, art. x, y, z). The abbreviation of the title will be marked in the first reference to it. The bibliography does contain the bibliographic details of the printed version of the Code of '04 as well.

The main contents of the Code of '04 (introductions, foreword and the Code itself) are the same in both publications²³. There is one important difference between the two publications of the Code of '04: The one on the website of the IOMS contained an appendix listing all their conferences and seminars since 1981 and up until, but not including, 2004. Together with the JIMA-article mentioned above, this appendix provides the study with material on the relevant development of the IOMS figuring as the background for the Code

²¹ It was lent to me by the University Library of Tübingen through an intra-library loan (ILL) during the fall of 2013.

²² It was provided by the University Library of Leiden, also through ILL during the early spring of 2014.

²³ A few typos and differences in spelling out Arab names are present. The biggest differences between the two publications are when the editor/author mistranslates or switches between prepositions (of/for/from).

of '04. As such, all of these materials are also treated as the subjective views of their authors and editors.

Both Speakers also required an examination of the organizations within their respective audiences. When finding data on these organizations, which in '81 were more obscure compared to the audience in '04, I have tried to incorporate information I could find within the main materials. Most of the time I had to rely on the organizations' own respective websites when finding information on their agendas and work. Some were described by the IOMS on their website, but such descriptions were short and most of them lacking in the necessary information (on what the organizations actually represented).

Representing the material

Most details pertaining to the method and application of the materials are central parts of the two Speaker-constructs of this study. As a result, information about the materials such as the structure of the Codes and systematic use of phrases is detailed in the chapters concerning their respective Speaker and Code. This is done to maintain integrity and focus to the depiction of the two different Speaker-constructs examined: They are a part of the Codes and their context, and are thus also objects of analyses as they too reflect their surroundings (such as when, for example, the structure of a message affects its contents).

As a student of the "history of religion" my main interests lie in examining the meeting between religious traditions and contemporary context, and the mechanisms of historical continuity adapting to its present surroundings. As a result, my study ended up with the twin focus of "the Speaker" and the Priest/Prophet-symbiosis.

Concerning the presentation of the opinions of the audience of '81, the sheer number of papers, technical details and contextual details of the authors themselves proved too much to give an account of. As a result I have chosen present the themes and opinions most of the papers agreed upon, with the criterion of being presented as relevant to ethical medical practice (which is the main theme of the Codes). This criterion made available parts of the more technical papers from scholars of medicine, but nevertheless reduces the presence of bio-scientific data within the study. Their opinions as representing their affiliations should still be valid when analyzing their place within the construction of the Speaker and the Code's contents.

The Codes of '81 and '04 were also both too large to quote all passages, but also too complex to base the analyses on just selected citations. I thus chose a two-part analysis for

them both: One was thematic and structural, the other was to define which elements and arguments of the Code were presented as “traditional”. The last analysis thus concerned the identification of Priestly and Prophetic claims to authority, based upon the first analysis. Nevertheless, the contexts of the Speakers were very different, and so were the contents of the Codes; defining exact themes to analyze both Codes by proved to be hard, and unsatisfactory as the changes of the Codes approach to IME are part of the developments of the Speaker-structure and its message.

As a result, the themes presented as summaries of the '81 papers, as well as the themes used to analyze the two Codes, are dependent on their respective Speakers' contextual elements. For example: The context of '81 centered more on a holistic view of medicine and the spiritual component of Islam as both medicine in itself *and* an ethical system. The context of '04, however, was more focused on specific topics and *fiqh*. These different approaches to IM and IME are reflected in the analytical themes I have used in chapter 4 and 5. The audiences pertaining to the different Speakers are thus identified as groups, either by nationality, professional affiliations, field of scholarship, organizational affiliation or thematic affiliation.

The question is: Which elements of the discourses pertaining to the Speakers of '81 and '04 are lost through this application of method? First of all, this question does not refer to which degree my depictions of the Speakers and the Codes of '81 and '04 are *true* or not. It refers to which parts of the discourses could be complemented by other perspectives or approaches to theory-cum-method (Cavallin, 2006, p. 18).

The biggest thematic factor of the discourses lost, partially due to both methodic approach and the scope of a Master's-study, are the contextual knowledge pertaining to the individuals referred to and contained within the materials. Socioeconomic, cultural, educational and traditional factors, and which implications they have on the individuals, are not to any large degree presented. A correlational study between the individuals of the study, their own contexts and the differences between the Codes would construct an even clearer depiction of the Speakers and the interrelation between their respective contextual elements. However, themes of social, economic, cultural and technological differences and problems are not totally absent from the analyses as they are included as themes within the materials, and are as such part of the Speakers and their messages. Their influence upon the individual speakers are however not a central methodic focus.

A second problematic loss, this in the larger context of the current study, is a lack of

pluralism when presenting the relevant conception of “Islam” and “modernity”. The study does include, and indeed centers on and is defined by, considerations of multiple discourses influencing the objects of study: the Speakers and the Codes. As such, it emphasizes the fact that the IOMS maneuvers an inter-discursive field consisting of several contestations on the same object, the field of global ethics. Nevertheless, the discourses are depicted through “their” representations contained in the main materials. The Codes and conferences were gathered in order to produce applied, normative ethics, and to regulate behavior. As a result, the concepts of “Islam”, “Islamic”, “modern” and “modernity” presented in this study are both monolithic and diverse at the same time²⁴, and depending on the contexts.

Unavailable elements of discourse due to lack of skills and knowledge

Due to the depictions of the Speaker-structures being built on materials representing official and public images of their elements, there can be other parts of the discourses which are closed in private amongst themselves (such as the IOMS). In addition, there are parts of the discourses which are unavailable to my study due to language barriers.

Both main publications of ’81 and ’04 were also published in Arabic, a language I do not possess knowledge of (as previously stated). The English volume of the main material from ’81 included the comments, discussions and papers made in English, but not the ones submitted and made in Arabic, consisting of “[...] a considerable portion of the proceedings [of the conference]” (El-Gendi, Hassan & Kidwai, 1981, p. 16). These were however included in the Arabic versions, along with translations of the English elements of the conference. The publication of the Code of ’04 makes no further mention of the contents of the Arabic version. The announcement for the conference concerning the Code of ’04 did however state that the conference would be in both English and Arabic, with simultaneous interpretations of both languages during the proceedings (IOMS, *Announcement: International Conference on “Islamic Code of Medical Ethics”*).

As a result, a larger part of the discourse would be available if I possessed knowledge of Arabic. Studies of the Arabic sources would be of considerable complementary value to my own. Several studies of the IOMS’ other works, and of Islamic bioethics, have been done by academics such as Mohammed Ghaly and Thomas Eich, both of whom included perspectives on the Arabic terminology used within the papers of the conferences and seminars (Brockopp & Eich, 2008, p. 58; Ghaly, 2012). Eich’s study of collective *ijtihad* also emphasized the

²⁴ As such, this refers to a general problem of defining a discourse which is not of my own original creation: Defining what “they say” implies a notion of what “I say”.

internal politics and biographical details as central factors to the resulting rulings/recommendations of such processes. Such details are referred to in Arabic sources (Eich, 2008, p. 73 n. 4). Ghaly explicitly points out the significance of the Arabic terminology within such studies, as well as the collective nature of the *ijtihad*, as the English translations and publications of materials simplify the vast areas of connotations, linguistics and philology contained within the study of *fiqh*-terminology (Ghaly, 2012, p. 209 n. 3). Knowledge of the terminology of *fiqh* is thus another discursive element missing. One that I speculate would change the nature of the current study.

Pertaining to the lack of Arabic is the partial unavailability of the biographical data of the individuals participating and central to the Speaker-constructs. Partial information is given by my main material, and further searches would be able to provide information on the level of interrelatedness between the different actors. This information can sometimes be found on Wikipedia (which I find dubious at best), and only on the largest, and known-figures, which are already emphasized as central to the Speaker-constructs. Lacking Arabic makes it difficult to verify sources where such information can be found, as well as discerning that information. Some biographical data has been obtained and put to use, but further availability would also contribute to a clearer depiction of the relevant discourses. Again, I suspect such information would also change the nature of the current study, as several networks of a core-group of people are implied, but their size and constructions are never completely verified²⁵.

Transcriptions, names and dates

All materials are in published in English by design of the original authors and editors. I take this to reflect a wish to communicate with an English-speaking audience in addition to the Arabic-speaking one. As a result I do not use a complete transcription of the Arabic terminology, keeping with the signs of a standard (Norwegian) keyboard and an American-English spelling as far as possible, without focusing on reproducing diacritical marks or replacing Arabic letters. Variations to the transcription may occur if deemed proper in a, for example, citation from the materials or other sources.

I have tried to standardize the spelling of Arab or other non-Western names. Such names have a large number of permutations when Latinized, which is also one of the reasons biographical data are hard to verify; in certain cases it is very hard to know if I am reading about the same person in different sources. All names are given in their most common and

²⁵ See chapter 4 and 5 on the “authors” and audiences.

simple spelling given within the materials.

The dates mentioned are taken as presented in the main materials. However, sometimes the authors, editors and translators have mistranslated between *Hijri* and Common Era (both ways), giving several different dates to the same conference or seminar (IOMS, *The Arguments of Islamic Law Rulings on Recent Medical Issues: Other Topics*). I have chosen to present the dates most commonly used and referred to, dating the two main conferences and their Codes to 1981 and 2004.

Materials found on the internet

Websites change names, servers and addresses on the World Wide Web. Along with the potential for uncontrolled change of contents and moderation from my side, websites can present any profile of an organization it may wish to. All websites used as materials in this study are the official sites pertaining to the organizations or journals, or under a domain linked to the official site.

For some studies it is pivotal to maintain an overview of the changes and moderations happening on the sites of material, especially if connected to synchronized forms of communications (like conferences or meetings over the internet) or those of both synchronous nature and of temporal displacement (like *fatwas*). The materials I have used from the internet in my studies are all specified as *temporal displaced* (not as transient as synchronous), approximating the status of normal, physical publications (Højsgaard, 2006, pp. 148-149). These internet sources are mostly used within the context of 2004, and are as such presenting information much closer in time to the relevant Speaker-analysis than to that of 1981. The contents of the websites function as contextual information as far as they describe the situation pertaining to either 1981 or 2004 (in a few cases to the years in-between). If not containing historical perspectives, and for example only stating an organization's parole or agenda in general, the value of the information itself have been treated accordingly as displaced in time.

Most of the websites used as materials concern other Speakers than the ones centered on the early and late conceptions of the IOMS to which they approximate in their Codes through the influence of the audience. A more detailed discourse could therefore be depicted through complementary studies of the detailed agendas of the different organizations and individuals within the Speaker at the exact time before and during the main conferences. As a result, I have limited my attentions to the larger and more easily identifiable parts of the

audience when analyzing the Codes.

Concluding remarks on method, Speaker-discourse and “critical” analysis

By choosing to analyze the construction of religious authority as per the theories explained and operationalized in chapter 2, I saw the methodologies/methods of discourse-analysis and critical discourse-analysis as the closest to the kinds of materials used. This was largely due to my interest in how authority is produced within a context of religion, and the potential for change within the established “institutions” of authority when meeting the challenges of contemporary contexts and modernity.

After applying my theory on my materials and consequently adjusting my analytical tools to their resistances, I reached a verdict concerning my own ambitions regarding theory and method: To study and understand discourses containing a variety of medical, historical and *fiqh*-scholars is doable within the limits of a Master’s-study, but only to a certain degree. To identify all implicit and explicit connotations, references and approaches, among the fields contributing to the production of such IME as described in the current study, requires an in-depth knowledge of both material and context which extends beyond just the details of the sources.

The methodology of *critical* discourse analysis of linguist Norman Fairclough as portrayed by Iver B. Neumann (2001, pp. 97-99) would require such in-depth knowledge for a “complete” application as a method of itself. It would further have to be adapted to the material, as not all discourses are governed by the type of processes pertaining to media or politics as described in such analytical models. Indeed, Lincoln emphasizes different claims to authority based upon different “stages” or contexts of communication (1994). The current study does in fact criticize what is explicitly stated through examining what is implied through the theoretical approaches explained in chapter 2. It is a question of which level of the discourse such criticism can be applied to (Neumann, 2001, pp. 50-55). By referring to Priestly and Prophetic authority, the production of “IME” is identified to be a construction of several discursive practices, and through identifying a Speaker over that of an “author” as having created the Codes, I identify the different fields the aforementioned discursive practices pertain to. The “identification” of these discursive elements is decided by the level of contextual knowledge attainable. This in turn decides the availability of the over-all discourses of my study.

Having contemplated the nature of discourses as stated in this chapter, and the nature

of how their implied effects are *conveyed* on the basis of their availability, I would like to conclude with the following: Should my study be referred to as within the methodology of *critical* discourse analysis, referring to the stipulations of Fairclough portrayed by Neumann (2001), then it should be as one of several needed complementary studies, pertaining to the multiple complexities of the inter-discursive field of IME and Islamic bioethics.

The methodological focus of this study is nevertheless one of discourse-analysis, the “discourse” defined to depict the “Speaker”-structure and the Priestly/Prophetic symbiosis within the Codes. The relation between the elements of the Speakers expressed in the Codes shows a conflict between tradition and context, where an ontological pluralism pertaining to several discourses contests within the production and application of religious ethics.

The possibility of the current study reaching qualified verdicts is strengthened through other research and publications on the field of IME, the IOMS and inter-disciplinary, collective methods of producing IME (collective *ijthad*). There are also several books on Islamic ethics of life, and of medical ethics, with different approaches but which gives an overview of the field. Comparing my own verdicts and conclusions with these other works should prove that my own conclusions are not purely attesting to the subjective realms of bias, prejudice and lack of contextual knowledge.

Chapter 4: The Construction of the Speaker and the Code, 1981

In order to claim authority, the message of the Speaker is shaped and influenced by its audience and their common context of communication. As a consequence, when analyzing authority according to the theory of this study, the structure and elements of the Speaker are as important as the Speaker's message.

To analyze the construction of the Speaker's message and authority, I will therefore have to give an account of the contextual elements described above: the Speaker's audience and their common context, in which the Speaker's message is presented. In order to see how these contextual elements have shaped the construction of the Speaker's authority, its message must be analyzed. This will be done by identifying the message's Priestly and Prophetic claims to authority, representing the legitimizing effects of tradition and reform due to the challenges of the Speaker's context.

Representing the constructions of the Speaker's authority are their "messages", the two Codes of IME, and their respective "contexts of communication", i.e., their respective process of production, presentation and publication. The Code of '81 was published as a part of a printed volume describing the structure of the Conference of '81, its organizers, participants, the papers presented, and the formal discussions taking place as a part of the Conference's program (El-Gendi, Hassan & Kidwai, 1981). The printed, physical volume will consequently be referred to as "the Proceedings".

The analysis contained in this chapter will start with examining the details of the production and presentation of the Code of '81. This will clarify the process of producing the Code before and during the Conference of '81, the circumstance it was presented in, and the process of the Code being approved by the Conference and included in its Recommendations.

As the Conference of '81 contained the parts of presenting and approving the Code, this part of the analysis will also examine who *organized* the Conference of '81 and influenced the agendas of its program, participants and the corresponding papers presented (the contextual elements to the Code). Examining the two groups of "authors" and "organizers" will highlight the relevant processes of producing the Speaker's message in '81, as well as the key-figures to the production of the Code and its contents.

The second part of the analysis delves deeper into the Code's context of presentation and its audience: the Conference of '81 and its participants. The first elements to be examined are the background and the agenda of the Conference of '81, in order to see why it was held.

By the time the Code of '81 was first published, the Islamic Organization for Medical Sciences was not yet officially constituted. One of the topics of the Conference of '81 and its concluding recommendations does however concern the early inception of the IOMS and its aims (El-Gendi, Hassan & Kidwai, 1981, pp. 560, 765). The Conference of '81 must accordingly be seen as the context of the presentation and production of the Code of '81, the IOMS, and their common agenda²⁶.

In order to define the type of audience the Speaker of '81 sought to influence with the Code I will give an account of the individuals and organizations participating at the Conference. This will also map out the relation between the attendants of the Conference and the "authors" of the Code to further show how the Code is related to its audience.

The next part will complete the examination of the elements within the Speaker-construct, by giving an account of the general opinions found within the papers presented at the Conference of '81 and its Recommendations. This will serve as the basis of comparison to the contents of the Code of '81, in order to analyze how the audience and the context of the Code have influenced the Code's contents and structure.

The last main part of this chapter, after analyzing the Code's context, will be an analysis of its *contents*. The first part this analysis will be thematic; in order to examine how it reflects the opinions of its audience and the topics of the Conference. Secondly, I will conclude with an analysis which concerns how the contents of the Code reflect the Speaker's claims to authority. This will be done by highlighting the interaction between Priestly and Prophetic elements of the Code of '81, made concrete by the various references and concepts pertaining to either tradition or context used in its composition.

The Context of Communication: The Code of '81 and the Conference of '81

Details of the production and presentation of the Code of '81

The Code of '81 started out as a draft written before the Conference of '81, by Dr. Hassan Hathout²⁷ (El-Gendi, Hassan & Kidwai, 1981, p. 730). It was next presented publicly near the end of the Conference of '81, held in Kuwait 1981, under the sponsorship of the Kuwait

²⁶ The Code of '81 is counted as among the publications of the IOMS even though the IOMS was officially constituted in 1984 (IOMS, *The Arguments of Islamic Law Rulings on Recent Medical Issues: Other Topics*). As such, the Code of '81 is considered a part of the early agenda and inception of the IOMS.

²⁷ A preliminary volume of the papers presented at the Conference was prepared by Dr. Ibrahim Al-Sayyad (at the time an Assistant Professor of Medicine at the Al-Azhar and head of dermatology in the Kuwait Ministry of Health) and given to its participants. The Proceedings does not state whether the volume was distributed before or during the Conference of '81, or if the Code of '81 was included (El-Gendi, Hassan & Kidwai, 1981, p. 16).

Ministry of Public Health and its Minister of Health, Dr. Abdul Rahman Al-Awadi²⁸ (El-Gendi, Hassan & Kidwai, 1981, p. 16).

Al-Awadi is throughout the Proceedings identified as the main lynchpin of the Conference of '81, through his position as the Kuwaiti Minister of Health and his encouragement and interest in the topic of IME. In the Special Recommendations of the Conference (additional elements to the concluding recommendations), Al-Awadi is also tasked with the establishment of the early IOMS (El-Gendi, Hassan & Kidwai, 1981, pp. 16, 28, 560, 760, 766). The Conference was also reliant on the cooperation of certain other individuals and organizations: The Crown-Prince and Prince of Kuwait, representing both the state and the Executive Board of the Kuwaiti Foundation for the Advancement of Science (KFAS²⁹); the National Council for Culture, Arts and Letters³⁰; the National Committee for Celebrating the fifteenth Century Hijri, and; the Organizing committee of the Conference, of which Hassan Hathout was the president. The Proceedings also mention the Under-Secretariat of the Kuwait Ministry of Public Health, thanking them for “financial affairs” (El-Gendi, Hassan & Kidwai, 1981, pp. i, 12–19). Authorities and institutions of the Kuwaiti state are thus considered to have figured prominently as organizers of the Conference of '81.

However, there are differences between the groups of the *organizers* of the Conference of '81 and the *organization* of the Conference of '81: Before the start of the Conference's first session, an Executive Board of the Conference and its President was elected³¹. These consisted of: Dr. Abdul Rahman al-Awadi (President), Dr. Ihsan Dogramaci, *Hakeem* Mohammed Said, Dr. Ibrahim Badran, Dr. Mehdi Ben Aboud, Dr. Ahmed El-Kadi, Dr. Hassan Hathout and Dr. Ahmed Rajai El-Gendi (El-Gendi, Hassan & Kidwai, 1981, p. 28). Most of these figures also chaired or moderated sessions during the Conference (El-Gendi, Hassan & Kidwai, 1981, pp. 19-23). In addition, Said, Dogramaci and Badran were tasked to join Al-Awadi in forming the early IOMS as a result of the Special Recommendations of the Conference, and to follow up on the other resolutions and recommendations given in the general recommendations during the Conference's closing session (El-Gendi, Hassan &

²⁸ Both Al-Awadi and Hathout are among the key-figures of the current study; further details on their (and others') participation in the Codes and works of the IOMS will therefore be presented throughout the rest of the study.

²⁹ The KFAS is an institution established by the late Amir of Kuwait in 1976, in order to promote scientific research and creativity across the scientific spectrum, in the “[...] understanding of the crucial role that scientific advancement plays in the wellbeing of a nation [...]” (Kuwait Foundation for the Advancement of Science [KFAS], *Director's Message*).

³⁰ Their “Heritage”-department is the one in closest cooperation, keeping a library with relevant photocopies of manuscripts and helping with the acquisition of new ones (IOMS, *At the local level*).

³¹ They were elected unanimously (El-Gendi, Hassan & Kidwai, 1981, p. 28). The Proceedings does not state by whom they were elected.

Kidwai, 1981, pp. 765-766).

The Code of '81 was presented by Hassan Hathout at the Conference as a topic of its own, titled "Seminar on the Kuwait project of the Islamic Code for Medical Ethics"³², with Hassan Hathout also being the chairman of the seminar. After being presented, the draft was discussed by "the delegates" of the seminar (names not given by the Proceedings) and approved after "a brief discussion" (El-Gendi, Hassan & Kidwai, 1981, p. 730). Following this seminar, the Code of '81 was approved and adopted by the Executive Board of the Conference, and included as the 7th recommendation (out of 12) as a conclusion to the Conference in its closing session (El-Gendi, Hassan & Kidwai, 1981, pp. 16, 764).

After the Conference of '81, the Proceedings were published (with the Code included corresponding to its place at the Conference) under the auspices and sponsorship of KFAS and the Amir of Kuwait, the Kuwaiti Ministry of Public Health and the Secretariat of Islamic Medicine³³, and the Kuwaiti National Council for Culture, Arts and Letters (El-Gendi, Hassan & Kidwai, 1981, pp. i, 18). Furthermore, the published volume of the Proceedings was "supervised and forwarded" by Al-Awadi, and edited by El-Gendi (from the Board of the Conference) along with two others (El-Gendi, Hassan & Kidwai, 1981, p. i). Thus far, the production, presentation and publication of the Code of '04 had seen the continued involvement by the various Kuwaiti authorities and institutions (through their organizing of the Conference until its completion and publication of its Proceedings), along with the figures of Hathout, Al-Awadi and El-Gendi. The institutions and figures organizing the Conference of '81 and those comprising the Executive Board and President of the Conference are thus considered to be the first element in the construction of the Speaker of '81.

The next element to be examined is the Conference of '81 and its participants, as they have implications on the Code through framing and influencing the Speaker-construct: they had the potential of influencing the standards, concepts and policies used by the Speaker to discuss Islamic Medicine, and its goals of producing normative Islamic Medical Ethics. The agenda of the Conference is what gathered the interested parties who participated, enabling the "stage" of the Speaker, the context of communicating the Code of '81. I will therefore start out by examining the background of the Conference and its agenda, before giving an account of its participants as listed in the Proceedings.

³² The Proceedings mentions this seminar under different names, all of them permutations of this title. The main elements between all the titles are "Seminar", "Kuwait project/document", "Islamic" and "Code of Medical Ethics", hence the choice of title.

³³ The Proceedings make no further mention of this institution.

Background and agenda to the Conference of '81

According to Al-Awadi, three specific occasions were said to have “greatly contributed to the emergence of the idea of establishing the [IOMS]” (Al-Awadi, 2000, p. 68). The first was a symposium on ethics and medicine in Cyprus, 1976, where no Muslim authority was available, nor assigned, to express an Islamic point of view on the topic of “The Islamic Concept on Some Medical Problems” (Al-Awadi, 2000, p. 68). Even though the symposium clearly had an interest in a specifically “Islamic” perspective on medical ethics, there was a perceived lack of qualified authority to give such a perspective.

The second occasion was at the University of Sorbonne, Paris, during a conference of the World Union for the History of Sciences. It was held during a time when Iran and Iraq warred against each other, which was reflected in the emotional response of the Iranian audience when the Iraqi professor speaking introduced ‘abu Bakr al-Razi³⁴ as an Arab (whereas the Iranians claimed he was Persian born). Al-Awadi later stated that the question of ethnicity or nationality was irrelevant and bringing unnecessary negative connotations into the theme of the history of *sciences*. The proper answer would be to regard him as *Muslim*, and thus identify “the Islamic civilization” as the origin of al-Razi’s work and legacy. This concept was thus to be re-injected into the historical narrative of science, and its centrality defended (Al-Awadi, 2000, pp. 68-69).

The third occasion was the advent of the 15th Hijri century. Not only was this the occasion of the Conference of '81 (the official creation of the IOMS being a part of its recommendations), but it was also treated as a symbolic occasion for the Muslim world as a whole. As such, the celebration was meant to embody the concept of *ummah* (the pan-Islamic community, perceived as connecting all Muslims through their religion) (Al-Awadi, 2000, p. 69).

In an article on the website of the IOMS, al-Awadi describes the zeitgeist at the time of the IOMS’ creation (around the time of the Conference of '81):

“[While Europe was growing stronger thanks to Arab and Islamic heritage], the Islamic nation was dwindling into the position of mere subordination to and dependency on its glorious past. Muslims have become so captivated by the models created by their great ancestors that most of their works are now helpless and repeated imitations of those models. Our ability to create new thoughts has come to a standstill.” (Al-Awadi, *A Synopsis of the [IOMS]*)

Rhetorically, the internal criticism in the quote above is minted on the stagnation of *Muslims* and the lack of a unified progression of scientific achievement within the *ummah*, akin to the

³⁴ Judging by the Conference of '81 he was perceived as a prominent historical Muslim figure; also known as Rhazes (El-Gendi, Hassan & Kidwai, 1981).

internal criticism presented by figures in the line of Muhammad ‘Abduh and Sayyid Ahmad Khan. The quote hints at apologetics in the face of Western encroachment, and the monolithic image of Islam and its heritage. However, the dominant implication is that of a contemporary need for Muslims to reform and “reboot” the Islamic intelligentsia. The background of the Conference of ’81 thus involved a program of intellectual reinvigoration and resurgence, which was to be based on, but not subordinated to, Islamic heritage and history (Al-Awadi, *A Synopsis of the [IOMS]*).

The over-arching themes of the background to the Conference of ’81 are first of all centered on defending a conception of “Islam” as a world civilization and a source of both scientific progress and ethics: There is an implied monolithic representation of Islam as both nation (*ummah*) and faith-based ethical system (during the symposium in Cyprus), as well as concept of an Islamic heritage belonging to the Islamic civilization (Al-Awadi’s answer to the conflict in Paris). However, the background to the Conference and the creation of the IOMS also reflects a resurgence of interest in the Islamic historical narrative (Al-Awadi, *A Synopsis of the [IOMS]*). This also entailed a focus on *heritage of Islamic medicine and science*, its role in the development of *modern* medicine and science, and a “[...] determination to establish [Islam] once again in the forefront of human endeavor” (Aly, 1983, p. 283). According to Al-Awadi however, before the Conference of ’81, there was a lack of authority available concerning matters of IME and Islam’s role within the history of medicine.

The foreword of the Proceedings, written by Al-Awadi, states that the Conference of ’81 was held in order to answer to the contemporary loss of scientific approach amongst Muslims and the Islamic world. The Muslim relapse to a state of stagnation was considered made worse by a perceived exploitation of the Islamic scientific heritage by the rest of the world. To set a resurgence of an Islamic science and culture into effect, the Conference of ’81 was held, during the celebration of the advent of the 15th *Hijri* century (Al-Awadi, 1981, pp. 12-13): “Now, by summoning this first International Conference of Islamic Medicine, we are trying to recreate the glories of our past, not through bombastic speech, but through learning and hard work. We also hold on to the scientific approach as a means of achieving our objectives.” (Al-Awadi, 1981, p. 13)

The invitations for the Conference of ’81 were consequently sent out to its participants asking for papers which would contribute to clarifying a position on the three main topical areas of the Conference of ’81: (1) The history of Islamic medical heritage; (2) the application of scientific studies on treatments and procedures found within the Islamic sources and the

heritage of Muslim physicians, and; (3) the principles and ethics of medical practice in relation to Islamic teachings (Al-Awadi, 1981, p. 13).

Participants of the Conference of '81

123 people affiliated³⁵ with 21 different countries are listed as “contributors” to the Conference in the Proceedings (El-Gendi, Hassan & Kidwai, 1981, pp. 767 – 781). 60% of all the contributors (74 out of 123) came from three countries: 30 from India, 26 from Kuwait and 18 from the U.S.A. Participants from India and the U.S.A. originated from different institutions and with a relatively large geographical spread³⁶. Of the Kuwaitis, 2 came from the Ministry of Waqf and Islamic Affairs and 15 were either primarily or secondarily affiliated with the Ministry of Public Health, reflecting the role of the Kuwaiti state and authorities in the organization of the Conference through their presence. The other 40% were affiliated with a total of 18 countries³⁷, not to mention the fact that U.S.A. and India constitute large portions of the world’s landmass. As such, the Conference of ’81 kept its title’s promise of an international profile (El-Gendi, Hassan & Kidwai, 1981, pp. 767 – 781).

Of the 123 people participating, 52 were *primarily* identified³⁸ as being professional academics or practitioners of medicine and 19 affiliated themselves specifically with the teaching or practice of traditional systems of medicine (*unani/tibb/advia*³⁹); 16 from India and 3 from Pakistan. 17 attendants were academics of humanities or education (3 had degrees in Islamic Studies from medical colleges), 4 were scholars of law (2 identified as practitioners of *fiqh*, both from Kuwait, and 2 non-specific), and 9 were academics within the natural sciences (mostly chemistry, but also zoology and veterinary science). 11 had a Ministry of Health as the primary affiliation, 5 participants were primarily representing different organizations, and there was one journalist from an independent journal at the Conference of ’81.

³⁵ The country, professional affiliation, career-field and other information processed in this study is taken as stated in the Proceedings; these details of the affiliations are not explicitly given in the case of several participants. Still, I have highlighted the interesting groupings and affiliations constituting contextual elements to the Speaker of ’81.

³⁶ The Indian participants included more groups originating from the same institutions than the U.S. participants.

³⁷ The other countries listed were: Spain (9), Pakistan (8), Egypt (5), Turkey (4), Indonesia (3), Tunisia (3), Syria (2), Morocco (2), Mauritius (2), South Africa (2), West Germany (2), Alger (1), France (1), United Kingdom (1), Uganda (1), Switzerland (1), Iraq (1) and Saudi Arabia (1) (El-Gendi, Hassan & Kidwai, 1981, pp. 767 – 781).

³⁸ Some had both primary and secondary affiliations, usually related to one another. As such, the divisions of these categories are slightly artificial, seeing as many may cross over into others and could have been labelled differently. 5 participants were without a defined professional affiliation (El-Gendi, Hassan & Kidwai, 1981, pp. 767 – 781).

³⁹ These were the relevant systems of medicine represented that to a larger degree includes religious and philosophical components, and the use of herbs and plants in medicine, than what was considered “modern” medicine (El-Gendi, Hassan & Kidwai).

In conclusion, the professional profiles of the Conference's participants were largely centered on the academics and practice of medicine (both modern and traditional) or complementary sciences and academics. A noticeable portion did however center on humanities, education, language and law.

The list of participants in the Proceedings lists only 5 people as representing an organization. However, several other organizations were involved in the Conference as well (El-Gendi, Hassan & Kidwai, 1981, p. 24). In order to further examine the profile of the audience and its relation to the "authors" of the Code and organizers of the Conference, I will give a summary of the organizations attending the Conference of '81 (other than the aforementioned KFAS and National Council for Culture, Arts and Letters).

A total of 27 universities and colleges had people either primarily or secondarily affiliated to them contributing to the conference. In addition, the organizations of interest involved in the Conference were: The Islamic Medical Association (IMA), the Medical Association of South Africa (MASA), the Islamic Center of Southern California (ICSC), the Hamdard Foundation, the Organization of Islamic Conferences (OIC) and the World Health Organization (WHO).

The IMA was represented by its early key-figures Ahmad El-Kadi and Abdul Rahman Chiakh Amine, the president of IMA, both of whom contributed with papers and spoke at the conference (El-Gendi, Hassan & Kidwai, 1981, pp. 769, 775; Islamic Medical Association of North America [IMANA], *IMANA History*). After their constitution in 1967 IMA started organizing annual conventions on different topics regarding Islam, Muslims and medicine; in 1977 they authored and adopted an "Oath of the Muslim Physician" as a Muslims alternative to the Hippocratic oath, and; in 1981 they were a key part of establishing the Federation of Islamic Medical Associations (FIMA), now a large international association of organizations (IMANA, *IMANA History*). Amine would also later work with Hassan Hathout in the IMA⁴⁰ ethics committee (IMANA, 2005, p. 33). The MASA were represented by Goolam M. Hoosen, which is interesting because he was also a founding member of FIMA, together with El-Kadi (El-Gendi, Hassan & Kidwai, 1981, pp. 774; Federation of Islamic Medical Associations [FIMA], *FIMA History*).

The ICSC, an organization centered on a liberal, but traditional view of Islam as the foundation for building an American-Muslim identity, was represented by its founder Maher

⁴⁰ IMA was by then known by their new name of IMANA (IMANA, *IMANA History*).

Mahmoud Hathout (El-Gendi, Hassan & Kidwai, 1981, p. 773; Islamic Center of Southern California [ICSC], *About Us*).

The Hamdard Foundation had its president and founder at the conference, Mohammed Said, a member of the Conference of '81's Executive Board (El-Gendi, Hassan & Kidwai, 1981, pp. 28, 778). Established in 1906 as an herbal medicine pharmacy in India, the Hamdard establishment later moved to Pakistan and established a foundation financing works of health, education and philanthropy: During the 80's they built an entire community called *Madinat al-Hikmah*, the city of knowledge and learning (Hamdard Foundation Pakistan [Hamdard], *Hamdard history*; Hamdard, *Journey of Hamdard*). As such, the Hamdard Foundation represents a considerable entity within field of medicinal plants, science and education.

The OIC was represented by Ekmeluddin Ihsahn Ughlu who spoke at the inauguration of the Conference (El-Gendi, Hassan & Kidwai, 1981, pp. 24). The OIC was founded by 25 states in 1969 as an inter-governmental organization meant to safeguard the interest of the Muslim world, and gained a permanent secretariat in Jeddah in 1970. The IFA of Jeddah is connected to the OIC, and was conceptualized in 1974, but not inaugurated until 1981 at the meeting of the OIC in January/February in Mecca and Ta'if, close in time to the Conference of '81 (Organisation of Islamic Cooperation [OIC], *About OIC*; OIC, *Subsidiary [Organs]*). Consequently, the OIC represents a large, international level of politics *and of fiqh*.

The last interesting participating organization was the World Health Organization (WHO), whom at least held a speech at the inauguration of the Conference (El-Gendi, Hassan & Kidwai, 1981, pp. 24). The WHO coordinates authorities on health policies and –strategies within the United Nations (WHO-EMRO, *About Us*). As such, at the Conference of '81 the WHO represented the largest element with a *global*-level agenda.

The organizations involved in and attending the Conference of '81 are thus representing national, international and global levels of policies and agendas. On the national level are the IMA, MASA and ICSC (as well as the Kuwaiti authorities and institutions earlier mentioned). However, through FIMA and other individual connections (the pivotal figures being Hassan Hathout and Ahmed El-Kadi) these national-level organizations take on an international role. The first aspect of the international presence at the Conference is therefore the Medical Associations and their agendas on Islamic medical practice (as in the case of FIMA and IMA). The second international aspect is the political one, represented by the OIC, and the third is the global profile of the WHO.

The profile of the organizational audience is mostly centered on an “Islamic

internationality” with regards to medical practice and ethics, complemented by the Hamdard Foundation (medicinal plants and philanthropic works) and the WHO (global medical policies). However, it is important to remember the 27 institutions of higher education the participants are affiliated with. As such, the background to the Conference, the three main areas of topics in the Conference’s agenda and the profile of the participants (the “audience”) are answering to one another, attesting to the *interrelatedness* of the ”author”, audience and context.

The next part will concerns the papers presented in order to complete the contextual elements of “audience” and “context” within the Speaker-construction of ’81. By giving an account of the opinions presented by the participants, I will build the basis of comparison towards the contents of the Code of ’81, in order to see the *interdependence* between the Speaker’s message, the audience and the context.

Structure of the Conference of ’81

The conference lasted 5 days, with 4 of those days containing between 5 and 9 hour-long programs of papers being presented. Each of those 4 days had either 2 or 3 sessions, with each session spanning between 2 and 2.5 hours, including a short time allotted at the end of each session for comments and discussions⁴¹ on the papers presented. According to the Proceedings a total 54 papers were presented at the Conference. The Proceedings also include 32 papers not presented at the conference, due to limitations on time, but that were available for the later publication⁴² (El-Gendi, Hassan & Kidwai, 1981, p.16). The papers in the Proceedings were chosen out of “almost five hundred papers” to represent different aspects of the three main topical areas of the Conference (Al-Awadi, 1981, p. 13). These papers were further sub-divided into 11 topics⁴³ at the Conference, each with their own session.

During the first topic of “What is Islamic Medicine?” 6 participants presented a characterization of IM according to their perspectives. Some speakers opted for a general characterization while others chose specific subjects to be handled under the banner of IM⁴⁴.

⁴¹ The discussions were used to elucidate upon a subject or topic presented in a paper by its author due to interest from the other participants; to support in general the opinions stated by other speakers, or; to further exemplify the themes of a session through concrete examples.

⁴² To go into detail on every one of the 86 papers included in the Proceedings lies beyond the scope and size of this thesis. However, the number of papers presented serves as grounds for identifying and summarizing the general views and opinions presented by the participants.

⁴³ The Proceedings also include a topic called “Miscellaneous”, which contained miscellaneous papers that did not fit into the general division of topics, but were chosen for implementation in the later publication of the proceedings.

⁴⁴ ...such as “Islamic solutions to modern resistant problems”, “Islamic maternity care” and “Quranic psychology”.

The next five topics were titled “Seminar on Ibn Sina”; “Historical Review: Study of selected work in Islamic Medicine”; “Achievements of Islamic Medicine in different branches”; “Clinical studies on therapeutic measures mentioned in Islamic Tradition or used by Muslim physicians”, and; “Pharmacological evaluation of therapeutic procedures used by Muslim physicians” (El-Gendi, Hassan & Kidwai, 1981, pp. 19-23, 31-494).

Although they contained different approaches to the concept of IM, the common denominators were Islamic history and heritage (precedents by figures such as Ibn Sina, Ibn Zuhri, Abulcasis and Ibn al-Haytham). The first three sessions dealt mostly with the role of Islam to the development of modern scientific methodologies, whereas as the last two sessions focused on the application of such methodologies to the teachings of medicine found within the “Islamic heritage” and the sources of Islamic tradition (El-Gendi, Hassan & Kidwai, 1981, pp. 121-494).

The next session, being a “Seminar on the philosophy of Islamic Medicine”, dealt with the twin aspects of the methodology and theory of Islamic Medicine in modern times. Again, the role of “Islam” in medicine and its importance was brought up, this time mostly focused on the use of medicinal plants as an alternative to modern synthetics where socioeconomic factors didn’t allow for Western medical institutions. “Medicine and the message of Islam” focused on three main areas: *da’wa* (missionizing) through medical practice, the topic of “Islam” being taught in medical curricula in order to secure morally upright medical professionals (and as *da’wa*), and once again “Islam’s” impact on the development of medicine and health (El-Gendi, Hassan & Kidwai, 1981, pp. 497-552, 567-614).

The 9th topic, “Medical Ethics as viewed by Islam”, concerned *fiqh*, medicine, and the concept of an Islamic code of medical ethics, including papers on both specific and general principles to be used in its production (El-Gendi, Hassan & Kidwai, 1981, pp. 617-687).

The last two topics, the “Special session: Meeting of the Board of the conference on establishing an Islamic Medicine Organization”, and “Seminar for discussion of the Kuwait project for a Code of Islamic Medical Ethics”, were the 8th and 12th sessions in line on the program of the Conference, with the final 13th session being on the 5th and final day, dedicated to the recommendations of the Conference. As such, these did not include the papers of the audience, but rather those of the Speaker, presenting the creation of the IOMS and the approval of the Code of ’81 (El-Gendi, Hassan & Kidwai, 1981, pp. 555-564, 725-751, 760-766). The papers presented are by the participants within the context of the Conference of ’81 and thus largely the “audience” in the Speaker-construct, whereas the Recommendations are the final products of the whole Speaker-construct. They will as such be presented last, after

the papers, as a summary of all the elements within the Speaker-construct contextualizing its message, the Code of '81.

The topics being discussed in the sessions of the Conference covered large fields of knowledge. However, most (if not all) papers touched upon two common themes: the characterization of Islamic Medicine and the relationship between the two identities of “Islam” (heritage and teachings) and “modern medicine” (scientific methodology). The following examination of the views presented at the conference, as a part of the context of the Code of '81, will be a summary of the common opinions among the presenters and their papers, as well as any notable divergent perspectives (which were few) presented at the conference or included later in the published Proceedings.

The papers and opinions of the Conference of '81

Islamic Medicine in general is presented as constituting a fusion of modern and traditional medicine, regulated by the Islamic tradition and its implications on ethical standards. In other words, IM is represented as a historical continuity, being a culmination of the “correct” teachings found within earlier systems of medicine (Galenic, Hippocratic and Vedic). These teachings were further developed by Muslim scholars (most of them polymaths) and thus created the fundamentals of modern scientific methodology, connecting IM to the contemporary “modern” system of medicine (Abdullah & El-Kadi, 1981, p. 66; Al-Fangary, 1981, p. 645; Al-Marzougi, 1981, p. 85; Barcelo, 1981, p. 96; El-Kadi, 1981, p. 37; Rahim, 1981, p. 90-91). As a consequence of this view, IM is both the pre-cursor to modern medicine and at the same time including the elements of modern medicine deemed “Islamic”. This includes most technology and treatments found within the contemporary developments of modern medicine, but filtered and controlled ethically in their applications to humanity through *fiqh* (El-Gendi, Hassan & Kidwai, 1981, pp. 79, 550; Atta-ur-Rahman, 1981, pp. 526 – 530; El-Sayyad, 1981, p. 46).

To complement the first broad characteristics is a second one of being “holistic”: according to the Conference of '81, IM encompasses the three factors of the human body, mind and soul, being a *complete* system of healing through both modern science and Islamic guidance, and is therefore presented as superior to that of Western medicine⁴⁵ (Muftu, 1981, p.

⁴⁵ “Western” is the term I have chosen to represent their reductionist and negative views of modern medicine its teachings, as modern medicine in that case is usually represented through statistics from the U.S.A or technology originating from the Western hemisphere (El-Kadi, 1981, p. 37-38).

623). “Western medicine” is viewed as lacking a spiritual component, failing to meet the qualitative requirement of philosophical consistency in its method and application which IM fulfills through being built upon the Islamic tradition (El-Kadi, 1981, p. 38; Syed, 1981, p. 101 – 105).

“Western” perspectives on history are first of all perceived as one single and unified perspective, and secondly as omitting the Islamic civilization’s role in the development of modern science, or of degrading the role of the Islamic scholarship to the status of “just parroting” Galenic and Hippocratic medicine⁴⁶. To ratify the lack of Islamic presence within the perceived historical narrative of medicine in “the West”, the common perspective among is that the “Islamic civilization” represented not only great, but also novel achievements of science and medicine (Al-Marzougi, 1981, p. 85; Aroua, 1981, p. 210; Barcelo, 1981, p. 96; Hamarneh, 1981, p. 171; Jabbar, 1981, p. 306; Jones, 1981, p. 230; Rahim, 1981, p. 90 – 91). In addition, historical cooperation between Muslim, Jews and Christians described in the sources of the Islamic tradition are emphasized as among the great features of IM (Abdullah & El-Kadi, 1981, p. 66; Muftu, 1981, p. 623).

Although the speakers at the conference have different elements contained within their definition of IM, the two aspects of “scientific method” and “Islamic teachings” are either explicitly stated or implied as being in a form of symbiotic relationship: Islamic Medicine is found within the Quran and the Sunnah, as well as in the teachings of great Muslim scholars and medical practitioners (most of them described as being polymaths). On the other hand, these teachings must be put to tests through modern science, which is also to be implemented into IM, after being deemed appropriately Islamic (El-Gendi, Hassan & Kidwai, 1981, p. 79; Abdullah & El-Kadi, 1981, p. 66; El-Kadi, 1981, p. 40; Syed, 1981, pp. 101, 109; Wagner, 1981, p. 543). Regarding modern developments the opinion is that if left without the guidance of Islamic ethics, modern medicine and technology is feared to do more harm than good. However, *fiqh* regulations concerning medicine must be based on correct and exact, scientific information (El-Deen, 1981, p. 638).

As a result of the presented centrality of both modern and traditional elements, a dual yet monolithic cultural identity, which is twofold in nature, is implied on a recurring basis: The Islamic heritage is judged as perfect for its time of origin, and should serve as the basis for a return to what is described as the historical Islamic hegemony within the scientific world

⁴⁶ This is referring to the previous authorities of medicine, Galen and Hippocrates, from which Islam is declared to be emancipated from, and indeed having fulfilled and corrected in the teachings of IM (Al-Marzougi, 1981, pp. 85 – 87, 88).

at the time, and; the current status of the Islamic civilization is viewed as being in a state of stagnation, either due to a lack of modern standards or through the Muslim mindset being unable to re-contextualize past glories. Relatively few papers mention the exact faults lying within Islamic society. Some mention a lack of understanding “modern science” as belonging to “Islam” and thus having an incomplete definition of IM. Others see the problem as a Muslim lack of adaptation to contemporary contexts and of being stuck on an image of a golden past (Al-Marzougi, 1981, p. 88; Atta-ur-Rehman, 1981, pp. 527-528; El-Kadi, 1981, p. 37; El-Sayyad, 1981, p. 46; Syed, 1981, p. 101).

A few participants did go into specifics on the faults of society. One dedicated his paper to problems concerning Mother-and-Child-care due to a lack of resources (Hifnawy, 1981, p. 70). Another paper connected the factor of socioeconomic inequality to a lack of education and medical personnel, resulting in high levels of maternal- and child-mortality, cultural fear of medical personnel and the spread of diseases such as tuberculosis and leprosy (Ali, 1981, p. 610-614).

However, such papers going into details of the problems facing Muslims were few, or problems of a socioeconomic nature were hastily mentioned, but not used as the main focus of papers. The focus seems to be on a perceived resurgence of the *ummah*, a revolution centered on restoring an “Islamic” hegemony (El-Gendi, Hassan & Kidwai, 1981, p. 285; Abdullah & El-Kadi, 1981, p. 66; El-Kadi, 1981, p. 47).

Perspectives on “modern medicine” and “science”

The role of the Quran and the Sunnah can be summarized as central to the common perspective on Islam as a “total” or “complete” way of life. It is also noted upon several times that the Quran is viewed as a book of guidance in life, and not one of detailed science, and must be treated accordingly as a tool in the re-contextualization of Islamic heritage. Others point to the ability of adaptation through the use of *ijtihad*, using the Quran and the Sunnah as the framework for harmonizing Islam to its contemporary context (El-Gendi, Hassan & Kidwai, 1981, p. 170; El-Sayyad, 1981, p. 46).

A number of references to tradition are presented as essential to the development of a past Islamic hegemony, and consequently to the development of contemporary modern science and medicine. Especially two prophetic traditions (*hadiths*) are seen as elementary: (1) God did not send down a disease without also sending down its cure and; (2) every illness has a cure, and when the cure is administered, the disease is healed by Gods Will (Al-Fangary, 1981, pp. 645-646; El-Kadi, 1981, p. 37; Shehata, 1981, p. 300). These teachings are stated to

have been the prime motivators of earlier Muslim scientists and should within the program of renewal and resurgence be the motivators of the following generations as well (El-Gendi, Hassan & Kidwai, 1981, p. 762): “This teaching implies that every available and useful treatment known to us should be utilized, and that if a treatment for a certain illness is not yet known to us, it is our duty to search for it until we find it” (El-Kadi, 1981, pp. 37, 40).

Another central reference to the Islamic tradition among the papers was that the coming of Islam forbade rites of magic, superstitions and “mythological” elements in the field of science and medicine. I paraphrase the hadith quoted as “Whoever goes to a fortune teller or diviner without the known credentials, and believes what he is told; he is a non-believer in Islam” (Al-Fangary, 1981, p. 646; Muftu, 1981, p. 623; Shehata, 1981, p. 300). According to the participants, this tradition was what enabled the development of a rational, scientific methodology and what is largely considered as the method of modern science among the participants, as it forbade superstition, forcing the use of sensory perception in medical practice. Ahmed Shawky Al-Fangary of Kuwait presented a paper listing the contributions made to modern science and medicine through inspiration by the sources of the Islamic tradition: Medical licensing of the requirements of the physician; the encouragement of medical specialization; obligatory cleanliness and hygiene as preventive medicine; acknowledgement of the infectious nature of disease; teachings regarding quarantine and control of epidemics; hereditary genetics; geriatrics, and; maternal- and child-care (Al-Fangary, 1981, pp. 646 – 647).

A few papers presented concerned specific principles of *fiqh* and their applications. These included: God’s sole ownership of the human soul and body resulting in a restriction on breaking the integrity of the body unless justifiable through *fiqh*; the rules concerning the priority of superior interests over inferior ones, and the prioritization of the public good over private interest; choosing the lesser of two evils and maximizing benefits; necessity overstepping prohibitions of *fiqh*, and; intention as the criteria in the judgment of actions. Resulting from the different applications of these principles is a framework of a medical practitioner’s obligations and responsibilities. It is stated that it is a legal duty of society, a *fard kifaya*, to include the necessary number of medical practitioners. In return it is the practitioner’s responsibility to “take care” of the patient, which doesn’t necessarily require curing the patient as long as the practitioner performs his duty to the utmost following the rules and stipulations of *fiqh*/the *sharia* (El-Deen, 1981, pp. 631 – 638; Gheddah, 1981, pp. 639 – 644).

The role of Islamic behavior and faith is seen as pivotal within the life of the medical practitioner. Ethical medical behavior is counted as *ibadah*, as a part of prayer/ritual worship, and the practice of medicine should be treated accordingly by both society and the practitioner. This in turn implies that medical education should be taught by “good Muslims” capable of presenting “praiseworthy examples” as role-models (Uddin, 1981, p. 578).

One paper not presented at the Conference, but included in the Proceedings under the topic of “Medical Ethics as viewed by Islam”, is of significant interest. It was handed in by El-Kadi and Amine of the IMA and included the IMA Oath of the Muslim Physician which they adopted in 1977. It was produced as a Muslim alternative to the Hippocratic Oath usually taken at modern medical institutions of education as a sign of committing oneself to an ethical practice of medicine (Amine & El-Kadi, 1981, pp. 656 – 657). Other papers also presented an “Islamic code of medical ethics” or an “Oath of the Muslim physician”, but the Oath by the IMA is chosen due to being an institutionalized Priestly oath within the central group of participating organizations and individuals related (through both agenda and connections) to the “authors” within the Speaker-construct.

The Recommendations

As a conclusion to the Conference of '81, the Executive Board of the Conference presented a total of 12 general recommendations concerning the field of IM and IME, where the 10th, 11th and 12th were thanks to the organizers and financiers of the Conference, and a call to the *ummah* to celebrate the onset of the 15th Hijri century with piety. In addition 3 special recommendations concerning the creation of the IOMS and the following up on the general recommendations were implemented at the end. Being a product of the background and agenda of the Conference, the Board, the participants and the organizers, the Recommendations were the products of all elements of the Speaker and also of its message, the Code of '81. The Recommendations are thus the summary of the Code's contextual elements, and the last item of comparison to its contents (El-Gendi, Hassan & Kidwai, 1981, pp. 760 – 763).

The 9 general recommendations concerning the state of IM and the implementation of IME were as follows: (1) the Conference of '81 should be followed by further conferences of the same nature; (2) the Islamic heritage and the way to a resurgence of the *ummah* and a hegemony of an Islamic civilization within the scientific world should be deliberated upon and implemented into educational curricula; (3) the heritage of Islamic Medicine should be studied together with, and completed by, other elements of Islamic culture and history; (4)

Muslim scientists should sponsor and/or do research providing verification of the traditional procedures in IM and make the results available to “all humanity”; (5) the “truth about the Islamic culture”, i.e. its influence upon the development of Western modernity, must be made clear to the rest of the world; (6) medical education should implement the teachings of the Conference, which in turn should be observed by *all* medical authorities; (7) ... this includes implementing the Code of '81; (8) an Islamic Council composed of scholars of *fiqh*, medicine and “life sciences” should be established in order to examine cases based on new scientific developments and which are without earlier precedence in *fiqh*; (9) a committee must be formed to follow up on these recommendations (El-Gendi, Hassan & Kidwai, 1981, pp. 763 – 764).

The special recommendations were: (1) the establishment of an Islamic Organization in Kuwait, to deal with IM and its heritage, research and implementation. As such, the organization should aim at (a) reviving IM, (b) encourage scholars to research IM by providing the necessary facilities, (c) encourage the establishment of like-minded national organizations, (d) develop medical curricula pertaining to the teachings of Islam and the Islamic heritage and, (e) establish a unified teaching of IME; (2) to commission Al-Awadi to establish that Organization, together with the Board of the Conference, and; (3) for the state of Kuwait to hold the Second International Conference of Islamic Medicine after one year (El-Gendi, Hassan & Kidwai, 1981, pp. 765 – 766).

As a conclusion to the Conference of '81 the focus of the Recommendations is both on emphasizing the importance of IM and its heritage, and to define the proper authority and network needed to both defend and further develop teachings of IM. When stating what those teachings might entail, the Recommendations refers to the “teachings of the Conference” and the Code of '81. I will thus continue with analyzing the contents of the Code of '81, in order to see how they relate to their context, and how the Speaker of '81 constructed the authority of its IME through Priestly and Prophetic claims to it.

The Islamic Code of Medical Ethics, 1981

The introduction of the Code clearly states its agenda:

“Like any force, biosciences need to be harnessed for the welfare of humanity, and be so guided as never to stray to be a destructive power, as happened to nuclear fission in the past. In the wake of application of modern discoveries in human reproduction, heredity, recombinant DNA and synthesis of behaviour – influencing drugs, our generation is witnessing a radical shaking of our heritage of moral values and codes of behaviour” (Hathout/[IOMS], 1981, p. 733).

The above citation from the introduction reflects the cautionary context stated during the Conference; the technological developments within (bio-) science need to be harnessed and

controlled properly. According to the introduction, the Code was endorsed by the Conference of '81 with the aim of establishing such control. Further on, the object of the Code is defined: "the adoption of this document by all medical bodies in the Islamic world is hoped to be an area we converge upon... in these times when there is so much that diverges us" (Hathout/[IOMS], 1981, p. 733). An interesting detail is the mention of divergence, that the *ummah* may not be as monolithic as hoped for; a concept that seems to be the aim of the Code and not necessarily the existing status of Muslim society and its medical practitioners.

In detail, the Code states that the audience should include: Every Muslim doctor, medical and paramedical students, medical scientists, and that "nonmuslim colleagues will also see in it a reflection of what God wishes man to be, and to do" (Hathout/[IOMS], 1981, p. 733). The medical professional, first of all Muslim, is thus identified as the main target audience of the Code. In addition, a later passage in the Code states that "This code shall be binding also to all personnel of all ranks in all fields of health care" (Hathout/[IOMS], 1981, p. 739). The ethical and educational message within the context of the Conference is also reflected in the introduction, as it restates its agenda as educating the doctor, student and scientist to lead a professional life within the teachings of Islam (Hathout/[IOMS], 1981, p. 733).

The Code is split into 13 parts, the first being the introduction, with further 12 numerated "sections" as the over-all topics of the Code: "Definition of the Medical Profession"; "Characterization of [the] Medical Practitioner"; "Relation between Doctor and Doctor"; "Relation between doctor and Patient"; "Professional Secrecy"; "Doctor's duty in War Time"; "Responsibility and Liability"; "The Sanctity of Human Life"; "Doctor and Society"; "Doctor and Bio-Technological Advances"; "Medical Education", and; "The Oath of the Doctor" (Hathout/[IOMS], 1981, p. 732).

These sections are further divided into guidelines, structured as (85) unnumbered bullet-points, with no set numbers of bulleted guidelines per topic or page. The bodies of text are generally not structured any further, mixing the specific guidelines and Priestly references to tradition. Sometimes a reference to a figure of the Islamic tradition (for example al-Ghazali) or contextual information (medical or *fiqh*) is added through their own italicized paragraphs. Such elements do not follow any further consistent structure or intervals and seldom are Priestly elements further developed into arguments or built upon: quotes from *hadiths* and the *Quran* (in English) consist mainly of just the citations.

The role and characteristics of the medical profession

Medical practice is defined as an act of worship and the medical professions are described as “noble” and “honored by God”. “Medicine” is defined as a holistic system where healing includes bodily, mental and spiritual aspects, and is a part of Islam’s “complete way of life”. The medical professional should therefore maintain a sturdy integrity, both personally and in his work. He should also be an ideal for both himself⁴⁷ and for others; he should be well-kept, tranquil, well-mannered, and well-spoken, all in order to both inform and heal the patients through social and communicative aspects of healing. The faculty of medical education should also provide a “good example” and make available his “experience, knowledge and acumen” to the students along with the teaching and continued guidance in and out of class, as well as before and after. Together, these characteristics found the basis of a medical professional whose fundamental aspect is explicitly stated as being a devout Muslim: A believer in Islam in all aspects of life, who never breaks character with the aforementioned personal and pious integrity (Hathout/[IOMS], 1981, pp. 734, 736, 738, 740, 743, 745, 750).

The goal of medical practice is “health”, but the responsibility of the medical professional is limited to be the best he can give. The physician is characterized as “a soldier for ‘Life’ only [,] defending it and preserving it as best as it can be, to the best of his ability”, and his integrity as a Muslim should provide the security of such an assessment (Hathout/[IOMS], 1981, p. 736). In return, the patient must trust in and abide by the prescriptions of the doctor (Hathout/[IOMS], 1981, pp. 740, 743). Another aspect of the fundamental concept of integrity is that the medical profession needs to abide by the concept of professional secrecy in a very strict sense, treating information extremely delicately, and with the uttermost truthfulness (Hathout/[IOMS], 1981, pp. 738, 741).

The characteristics of the medical profession thus far mentioned are also to be applied in the relationship *between* medical professionals, which is considered a brotherhood of sorts, and a resource: The effect of multiple medical professionals should be additive, and not competitive, towards both the treatment of a patient and the personal relation between the professionals. All cooperation must happen in honesty and good faith for the interest of the patient, and if working in a team is natural to the situation of healing the patient (cooperation *must* be sought if specialists are required), then medical professionals are required to foster the “team-spirit” (Hathout/[IOMS], 1981, pp. 738-739, 743). In order for the medical workforce of society to be intact and operative, doctors need to quickly aid one another if either themselves or any of their close relations get sick (Hathout/[IOMS], 1981, p. 739).

⁴⁷ It is implied throughout the Conference and the Code that the practitioner is male. Further perspective on sex, body and language has been left out of the study due to limitations on size and theoretical scope.

Several aspects of the papers of the Conference are emphasized in the Code's topics of medical education, licensing and which fields of knowledge the medical profession should be familiar with: The medical professional of the Code should to a degree reflect the ideal Muslim, polymath scholar of "the golden age" presented in the papers of the Conference. He is in need of a proper education as well as a recognized certification that the required standards of practical, theoretical, ethical and philosophical training are met; a medical license pertaining to the perspective of the Code (Hathout/[IOMS], 1981, p. 743).

The medical professional should know "[...] a threshold knowledge of jurisprudence, worship and essentials of Fiqh" (Hathout/[IOMS], 1981, p. 736) in order to attend holistically to the Muslim life of a patient. A part of this lies in "[sparing] no effort in avoiding the recourse to medicine or ways of therapy" that are considered to be prohibited or forbidden in Islam (Hathout/[IOMS], 1981, pp. 736-737).

In addition, the medical profession must also be able to work with, and take council from, modern technology and science (Hathout/[IOMS], 1981, pp. 737, 745, 748-749). Together, the two fields of *fiqh* and medicine constructs a medical professional whose relationship with the continual developments within science and medicine goes both ways, as

"The Medical Profession has the right and owes the duty of effective participation in the formulation and issuing of religious verdict concerning the lawfulness or otherwise of the unprecedented outcomes of current and future advances in biological science. The verdict should be reached in togetherness between Muslim specialists in jurisprudence and Muslim specialists in biosciences." (Hathout/[IOMS], 1981, p. 748)⁴⁸

This quote is perhaps one of the central elements of the Code of '81 with regards to its concept of authority and Prophetic claims to it. First of all, the Code clearly states that medical professionals should be considered central to the further development of *fiqh* regarding the field of medicine and biosciences, together with traditional *fuqaha*, calling for the practice today known as "collective *ijtihad*" in order to compensate for the "lack of comprehension of technical or legal aspects" provided by "single-sided opinions" (Hathout/[IOMS], 1981, p. 748). As a consequence, not only does the Code routinize and rationalize the concepts of modern science and medicine within a system of ethics, but it also explicitly states the method of doing so through collective *ijtihad*. The Code is therefore shown to be explicitly applying Prophetic claims to authority as the ethics of Muslims are decided in cooperation between traditional and modern scholars.

Society and the medical profession

⁴⁸ For example, creating and implementing regulations on scientific developments and institutions, such as organ banks (Hathout/[IOMS], 1981, p. 748).

On the macro-level, the “state” needs to meet the required level of educational and medical institutions on all levels of health care within “the Nation”: Similar to the papers of the Conference, the provision of medical practice is depicted as a *fard kifaya* upon a community, a collective duty. This also includes acquiring medical expertise from afar, to recruit suitable candidates for training, and to establish the relevant schools, faculties and institutions with the proper equipment for the purpose of education. The education should reflect and build the characteristics of the medical professions as stated above, including the demands on knowledge of modern medicine, science, *fiqh* and worship, and the Islamic heritage of medicine, including knowledge of the Code itself (Hathout/[IOMS], 1981, pp. 734, 750). The status of medical practice as *fard kifaya* is also used to establish medicine as a *necessity* (an object of *fiqh*), along with the exceptions needed for implementing the required level of education and scientific development, such as the examination of the human body, as long as it is done with a religious correct intention (Hathout/[IOMS], 1981, p. 734).

In return, the medical practitioners are jointly responsible for the care of “the Nation” and should complement each other’s practice by their specializations and areas of employment. This includes working together in order to push forth legislation and policies needed to implement the needed institutions and measures for the best possible health to society. To do this, the medical profession is tasked with studying “at first hand the data, facts, figures and projections of various parameters actually existent in Muslim societies. Upon this should be decided what to take and what to reject from the experiences and conclusions of other societies” (Hathout/[IOMS], 1981, pp. 738, 746).

Providing a “good example” as a Muslim medical practitioner is included in the definition of “preventive medicine”, such as the prevention of smoking, illicit sexual licensing and climate pollution, which should all be elucidated upon by the medical practitioners of a society (Hathout/[IOMS], 1981, pp. 736, 746). However, no specific system of funding or resources are made, nor any considerations if there even is a functional state or unified nation to begin with⁴⁹. The medical professional should be compensated by society on part of the role he inhabits, founding the basis of “[...] his right to be trusted, to live comfortably, to earn an adequate income and to keep his dignity” (Hathout/[IOMS], 1981, p. 746).

On the micro-level, the same vagueness characterizes the agenda of funding medical services. The socioeconomic divide between “rich” and “poor” is mentioned several times. “Health” is counted as a basic human necessity and should be provided regardless of the

⁴⁹ The point here isn’t to remark on all elements “missing” from the Code, but to underline certain characteristics of it.

resources of the patient, who should not be denied service due to his inability to meet the cost. In situations of necessity or emergency, this also applies to the practitioners of private practice. There is however no considerations of which social-class the medical practitioner in reality belongs to, or the economic environment he has to maneuver in order establish a functioning practice. However, medical professionals are “Fully entitled to make a decent living and earn a clean income” (Hathout/[IOMS], 1981, p. 740) leaving the responsibility split between the macro/micro-level, depending on the society he is practicing in.

Other considerations of the socioeconomic divide lie in the relationship between patient and doctor:

“[...] a patient is in the sanctuary of his illness and not of his social eminence, authority or personal relations. [...] The sphere of a Doctor’s charity, nicety, tolerance and patience should be large enough to encompass the patient’s relatives, friends and those who care for or worry about him [...]” (Hathout/[IOMS], 1981, p. 740).

This last element also reflects on the necessary integrity of the medical professionals presented throughout the Code. As such these socioeconomic ideals are prevalent in its message, but less so the methods of implementing them, keeping with the main level of socioeconomic aspects being dealt with in the papers presented at the Conference: A vague agenda which rarely had specifics attached to it.

The Code’s stance on war and scientific advancement and the medical profession

On the subject of violence, the Code states that “God’s mercy is accessible to all” and that medicine is part of God’s mercy and should never be motivated by feud or enmity that is based on personal, military or political factors (Hathout/[IOMS], 1981, p. 734). Reflecting the characteristic of the required integrity, the doctor should stick to his task of protecting life in war, and not be swayed by neither friend nor foe into changing course of action. This course should be taken on a global scale, and doctors should promote it through international unity (Hathout/[IOMS], 1981, p. 742). This results in the general principle of “The doings of the Doctor shall be unidirectional aiming at the offering of treatment and cure to ally and enemy, be this at the personal or general level” (Hathout/[IOMS], 1981, p. 742).

As stated in the Code, “The Physician should strive to keep abreast of scientific progress and innovation. His zeal or complacency and knowledge or ignorance [...] directly bear [Sic.] on the health and well-being of his patients” (Hathout/[IOMS], 1981, Hathout/[IOMS], 1981, p. 737). Furthermore, the pursuit of knowledge is stated to be a mode of worship in itself (Hathout/[IOMS], 1981, p. 737). As such, it is both indirectly implied and explicitly stated throughout the Code that “there is no censorship in Islam on scientific

research” (Hathout/[IOMS], 1981, p. 748).

A few regulations are given on scientific research, that it should not “[...] entail the subjugation of Man”, cruelty to animals, or “[...] the commission of sin prohibited by Islam”, such as fornication, the confounding of genealogical lines, and the tampering of the human personality (Hathout/[IOMS], 1981, p. 748). Regarding the medical profession’s scientific knowledge: “The Medical Profession shall not permit its technical, scientific or other resources to be utilized in any sort of harm or destruction or infliction upon man of physical, psychological, moral or other damage [...] regardless of all political or military considerations”, reflecting the general principle above (Hathout/[IOMS], 1981, p. 742).

The Code and its context

Concerning the relation between the contents of the Code and the topics of the Conference, the Code is more focused, and thus more specific, on the role of the medical practitioner; the Conference had far wider and partially more abstract themes as a whole. However, the Code reflects the contents of the *papers* of the Conference in two ways: (1) Even though the theme of the Code is more specific than those of the Conference, or at least has a specific focus, the nature of the Code’s guidelines is that of *general principles* of an Islamic practice of medicine, and; through being general principles, but of a specific focus, the Code *emphasizes* the characteristics of IM and the role of Islam as generally described in the papers of the Conference’s participants, as well as building further upon them. As such, the Code can be said to constitute of general guidelines on a level between the abstract of the *Quranic* moral imperative and the normal casuistic perspective of *fatwas* or other rulings by Islamic *fuqaha*.

The Code reflects many of the opinions framed during the Conference of ‘81: IM is a holistic system, integrating several factors of the human mind, body and society, as well as religious aspects. Medicine is described in a natural state of being under Islamic ethical control, through the figure of the pious Muslim medical professional with competence within several fields of knowledge. Furthermore, the IME is emphasized through medical practice being defined as an act of worship and a *fard kifaya* upon a community; physicians should provide “good examples” and be role models, and; the methodology of scientific research and its application should follow the ethics of Islam. The same reflections are found within the topic of medical education, which should not only build the “Muslim doctor” role-model, but also “be protected and purified from every positive activity towards atheism or infidelity”, a process which includes the implementation of a new “Oath of the Doctor” presented as the

last topic in the Code. As such, the Code is becoming more related to its context of organizational audience (especially IMA), and the agenda of institutionalized IME.

Compared to the general tone of most of the Code, some parts specifically brings up certain topics, like preventive methods against smoking, environmental pollution and venereal diseases, gonorrhea and syphilis. These last two are pointed out as reaching “epidemic proportions” in “certain developed countries” where sexual license is stated to be out-of-bounds for the current medical practitioner, and should only be treated, not moralized upon (Hathout/[IOMS], 1981, p. 746). Fetal Medicine and the “modern permissive abortion policies not sanctioned by Islam” are brought up as examples of the modern scientific development, along with the donation of bodily fluids and organs: blood transfusion and organ donation and transplantation. In fact, the establishment of a proper donor-culture is stated to be another *fard kifaya* under certain regulations such as the necessary absence of social or economic compulsion as motivators for the procedures (Hathout/[IOMS], 1981, pp. 744, 748). First of all, the Code is emphasizing a lack of ethical guidance within modern medical treatment and application of technological developments. Secondly, it also constructs a monolithic concept of Islamic ethics as a unified system, thus leading to a unified code of behavior for the *ummah*.

As such, the Code concerns the practical reality of society, the need for an Islamic solution to the problems facing it, as well as a solution to the perceived problem of stagnation and lack of progress within the Islamic world. The need of ethical regulations based on the religions of Islam for the medical profession is in both the Code and its context perceived as crucial in order to harness the potential of scientific development and its related impact on life ethics: “Mercy killing – like suicide – finds no support except in the atheistic way of thinking that believes that our life on this earth is followed by void” (Hathout/[IOMS], 1981, p. 744).

The Code and its audience

The Code gives the medical profession responsibility of pushing forward legislation in favor of its implementation. As such, the audience consisting of the “medical profession” includes policy-makers within international and national organizations and institutions of ethics and legislation. This image of the Code’s audience is more or less fulfilled considering the number and size of influential organizations attending the conference at its time. The constant reference to the “state’s” duties towards society and “the Nation” further underlines this implication as well as invitations to international cooperation like: “As part of international medical family, Muslim Doctors should lend all support on a global scale [...]” (Hathout/[IOMS], 1981, p. 742).

The Code also acknowledges the cooperative nature of medical practice within different medical institutions, consisting of several fields and levels of health care, which also coincides with the holistic image of IM (Hathout/[IOMS], 1981, pp. 739, 741). As such the unity of the medical profession is also pointed out as central to the continued ethical practice of medicine globally. The global perspective is included in the focus on the doctor and society, giving a central role to the practice of preventive medicine, and underlining the need for the study of the actual parameters of society, in order to properly apply strategies on medical practice to its target context, and to lessen the “uncritical copying of alien experience” (Hathout/[IOMS], 1981, p. 746).

The contents of the Code thus answer to the presence of IMA, MASA, and the early inception of FIMA. Neither are the ICSC and Hamdard, nor the persons of Maher Hathout or Amine peripheral; they complement to the building of the relevant image of Islamic ethics and their application in society. In addition, the same can be said of the participating elements of international Muslim politics: the OIC, the state and authorities of Kuwait, KFAS, the Amir and Al-Awadi. The presence of the *global*-level element of WHO is reflected in the Code of '81 through the early inception of an agenda on the socioeconomic aspects of medicine.

The second group to be implied as the Code's audience is the *fuqaha*. Considering the title of “Islamic Code of Medical Ethics”, it's not surprising that bodies of both medicine and Islamic ethics, and *fiqh*, are part of the target audience. That the “[...] physician should be amongst those who believe in God” (Hathout/[IOMS], 1981, p. 736) is prevalent in the shaping of the Code's message. The audience seems to require the same necessity as medical professionals of knowing a basic amount of “jurisprudence, worship and essentials of Fiqh” (Hathout/[IOMS], 1981, p. 736): the maxim of “necessity overrides prohibition” is given only a short explanation; on the topic of “the sanctity of human life”, the language is kept directed at both medical professionals and *fuqaha*, switching from explaining points of the topic between the *fiqh* and medical sides (Hathout/[IOMS], 1981, p. 744). Concerning the quote on collective *ijtihad*, i.e. the cooperation between *fuqaha* and medical specialists in developing *fiqh* on medicine (Hathout/[IOMS], 1981, p. 748), the Code definitely aims at the audience of *fuqaha*, and organizations, policy-makers and legislators also touching upon the subject of *fiqh*, as well as any relevant representatives of non-religious jurisprudence.

Identifying the Speaker's claims to authority: modern contexts and traditional doctrine

The Priestly claims to authority in the Code are first of all based on references to Islamic traditional figures, Quranic verses and *hadiths* (Hathout/[IOMS], 1981, pp. 734 – 738, 740 –

744, 746, 748 – 750). Included in this are the references to the secondary principles of *fiqh*: “necessities override prohibitions” and “warding off” the ‘bad’ takes priority over bringing about the ‘good’” (Hathout/[IOMS], 1981, p. 743). As such, both the Code and the Conference presents us with a relatively “light” introductory level of Priestly claims to authority based on the direct citations and references to *fiqh* alone.

However, it develops as those claims are applied to the context of IM in order to develop the more specific agenda on IME. For example: References to *fiqh* serves to delimit the medical profession, stating that “Human Life is sacred [...] and should not be willfully taken except upon the indications specified in Islamic Jurisprudence, all of which are outside the domain of the Medical Profession” (Hathout/[IOMS], 1981, p. 744). This refers to the Quranic verse which also figured in the papers of the Conference as well as in the “Oath of the Muslim Physician” by IMA included in the Proceedings:

“On that account we decreed for the Children of Israel that whoever kills a human soul for other than manslaughter or corruption in the land, it shall be as if he killed all mankind, and who-so-ever saves the life of one, it shall be as if he saved the life of all mankind” (Hathout/[IOMS], 1981, p. 744, [my underscores])

The more complex Priestly factors of the Code lies in its rationalization of the medical profession within the theological aspects of Islam: First of all, the inclusion of an “Oath of the Muslim Doctor” is alone a statement on the role of Islam within the medical profession. The Code also states that “medical knowledge is part of the knowledge of God”, “The study of Medicine entails the revealing of God’s signs in His creation”, and “The practice of Medicine brings God’s mercy unto His subjects” (Hathout/[IOMS], 1981, p. 734). Together with the assessment of medicine as *fard kifaya*, the regulations and characterizations of the medical profession is presented in the Code as religious concepts. By the grace of practicing medicine, being “amongst those who believe in God” (Hathout/[IOMS], 1981, p. 736) and possessing basic knowledge of *fiqh*, jurisprudence and worship, the physician is even counted as an instrument of God’s justice, forgiveness and coverage, as well as “a catalyst through whom God, the Creator, works to preserve life and health” (Hathout/[IOMS], 1981, p. 737). On the topic of medical education, the standards of the medical profession are repeated, along with the characteristics of being a religious institution and a part of the belief in God (Hathout/[IOMS], 1981, p. 750).

The Prophetic elements of the Code are first of all its connections to its context, that of the Conference and its participants. They are primarily found within the mechanism of rationalizing elements of modern medicine within the Islamic tradition, through the

application of the Priestly claims to authority mentioned above. Pivotal to the Prophetic claim to authority is the rationalization of modern scientific methodology and research, and its role in an Islamic practice of medicine (the pursuit of knowledge is *ibadah*, and the knowledge of modern science is stated to be obligatory to the Muslim medical professional). The Code's contestations on IME and the role of Islam as relevant can be seen as based on Islamic values, but also largely on the implementation of modern science and medicine within the concept of "IM". As a consequence, the Code joins with the participants of the Conference and their papers in their contestation of the narrative of the history of medicine: the pivotal role of an Islamic civilization to the development of science and medicine. As such, the Prophetic claims to authority are not as explicitly stated as the Priestly.

Claims to authority are for example shown to be Prophetic when the doctor's duty to share his experience with the younger generations of doctors and students isn't only argued for by referring to tradition, but also to the contextual need of passing on knowledge in general (Hathout/[IOMS], 1981, p. 738). Another example of the Prophetic identity of the Code is the reference to the global and international context: "As part of the international medical family [...]" (Hathout/[IOMS], 1981, p. 742), reflecting the context of the Conference and its international profile. Another example of explicit Prophetic authority lies in the following quote:

"[...] the sanctity of human Life covers all its stages including intrauterine life of the embryo and fetus. This shall not be compromised by the Doctor save for the absolute medical necessity recognised by Islamic Jurisprudence. [...] This is completely in harmony with modern medical science which lately has embraced a new speciality called Fetal Medicine [...]. Modern permissive abortion policies are not sanctioned by Islam, which accords several rights to the fetus. [...] The basic right to life of the fetus is [through several examples of *fiqh* shown to be] self-evident" (Hathout/[IOMS], 1981, p. 744 [my underscores]).

The shifts between legitimizing tradition through modern science, and vica versa, results in Priestly argumentation combined with the Prophetic elements of the authority given to contemporary context (Fetal Medicine). The Code's context has leading implications on its contents, where professionals of both modern and "traditional" (*tibb/unani*) medicine introduce Prophetic claims to authority by relying on the legitimizing effects of referring to modern medical theory and practice.

The second Prophetic claim to authority is how the contents of the Code of 1981 reflect the high level of interrelation between the elements of the Speaker-construct. The clearest manifestation of the combination of Priestly and Prophetic claims to authority, and the acknowledgement of its necessity to the development of the Islamic tradition in the eyes of the Code and the Conference, is the ruling on the need for collective *ijtihad* (Hathout/[IOMS], 1981, p. 748). "Collective *ijtihad*" can thus be said to best represent the

concept of authority used in order for the Code's contestations on IME to maintain relevance. The Prophetic claims to authority are in conclusion found within the rationalization of modern medicine within tradition through the application of the concept of Islamic Medical Ethics.

In this chapter I have identified the Speaker-construct of '81. It consisted of "authors" related to an audience of international, Muslim medical and political networks. Together they created the Conference of '81 and gathered an audience under the banner of IM, and a program of its resurgence. As such, the organizers and the audience both reflected and constructed each other's agenda. This is shown in the Speaker's message, the Code of '81, through both its overall themes and its claims to authority: Those of a Priestly, traditional "institution", and those being Prophetic through the authority of modern science and medicine, routinized and made rational within the agenda of the participating networks.

The construction of the Speaker's authority describes how the Code reflects the dominant structures of power/authority. An example of this is how the Code lacked any significant, specific focus on the role of "traditional" medicine and the socioeconomic implications of using herbal medicine as the basis for health within a society; these views were not represented by the dominant elements within the Speaker. The Code is draws on both Priest and Prophet through the call for *ijtihad* within complementary sciences, now all defined as *within* the concept "tradition" relevant to the current study: It is framed and produced within the agenda of re-contextualizing the past, through rationalizing the present, in a program of renewal, resurgence and reform of the Muslim medical profession and its practice.

Chapter 5: The Construction of the Speaker and the Code, 2004

The Code of '81 prescribed some specific, but mainly general principles of how the tradition of Islam should be applied to the medical profession, how the medical profession should be applied to society, and how the medical professional himself should apply an "Islamic" practice to the patient.

23 years later, in 2004, the Islamic Organization for Medical Science (IOMS) produced the *International Islamic Code for Medical and Health Ethics* (the Code of '04) at the 8th International Conference on Islamic Medicine in Cairo, Egypt (the Conference of '04). In the foreword of its publication as a book, Al-Awadi states the Code of '04 to be the *compilation* of the IOMS' work within the field of IME, comprised of seminars, conferences and research on medicine and *fiqh* (Al-Awadi, *The International Islamic Code for Medical and Health Ethics: FOREWORD*). The Conference, and the Code of '81 presented by Hassan Hathout, constituted the *creation* of an identity of the IOMS and their perspectives on IM and IME. In the current study, the Code of '04 thus represents the *continuation and development* of the identity as a Speaker created in 1981 to that of the new Speaker-construct of '04.

As a consequence the Codes of '81 and '04 are different, reflecting the change in the constructions of their respective Speaker's authority. In 2004, the whole Conference was dedicated to the production of the Code of '04, which is a considerably larger document both in scope and size compared to the Code of '81. In addition to being culminations of the work and teachings of the IOMS, they were also the result of an international cooperation between several large organizations with global agendas on health, medicine, research and their application (Al-Awadi, *The International Islamic Code for Medical and Health Ethics: FOREWORD*).

The first part of this chapter concerns the process in which the Code of '04 was authored, edited, presented and published. As the Conference of '04 was dedicated to the production of the Code of '04, it will play a prominent part as I examine and identify the "authors" of the Code of '04.

The second part of analyzing the Speaker, and the Code's context, concerns the background and agenda of the Conference of '04. The Conference of '04 was of a different nature than the Conference of '81, and did not revolve around papers or other main topics than the Code of '04. In order to examine the background and agenda of the Conference and the Code of '04 I will give a summarized account of the development and work of the IOMS

up until 2004. Highlighting the relevant developments of the IOMS as a Speaker will clarify why the audience participated at the Conference, and elucidate upon the main topics of the Code of '04.

The third contextual element within the Speaker to be examined consists of the audience: The participating individuals and organizations, and what they represented. Giving an account of the participants will both emphasize the change of profile within the audience of the Speakers, and highlight which other bodies of global ethics, international cooperation and Islamic authority the Code of '04 relates to.

After examining the construction of the Speaker of '04, the Code of '04 will first be thematically analyzed. This will show how the Code's contents and structure have changed in accordance with a new context compared to the Code of '81. Secondly, I will analyze and identify the Priestly and Prophetic claims used to construct the authority of the Speaker of '04, within the Code of '04. This will emphasize both the construction of authority within the Code and its Speaker, but also how the Priestly and Prophetic elements have changed with the new context, together with the relation between them.

The Context of Communication: Production, presentation and publication under the banner of the IOMS

The process of authoring and presenting the Code of '04

The Code of '04 in its entirety consists of three parts: (1) "Medical Behavior and Physician Rights and Duties", (2) "International Ethical guidelines for Biomedical Research Involving Human Subjects – An Islamic Perspective", and (3) "The Arguments of Islamic Law Rulings on Recent Medical Issues, Based on the Recommendations of IOMS" (El-Gendi, 2005, p. 25). These three sections represent the key areas of authority perceived as necessary to produce qualified IME in the Code of '81, on the need for collective *ijtihad: fiqh*, medical and scientific scholarship should cooperate in order to produce IME from several perspectives. By using different sources of information and knowledge, the IME would be both wider and more defined in their application than any single element of scholarship could produce alone (Hathout/[IOMS], 1981, p. 748).

The main objective of analysis is, however, the first part of the Code of '04, on the behavior, rights and duties of the physician. There are two reasons for this: First of all, due to the scope and size of this thesis, part 2 and 3 will be included as an aspect of context to the Code of '04, but not as main materials analyzed into the construction of the Speaker of '04.

The “Code of ‘04” is mainly used to refer to part of the Code, unless stated otherwise⁵⁰. The second reason for choosing the first part as the object of analysis is that it answers to much of the same language and concepts (regulated by contextual developments) as the Code of ‘81, which makes a comparative analysis of the two Codes more accessible.

The production of the Code happened mostly in a collective manner, and the three parts of the Code had similar, but slightly different processes. Compared to the process of producing the Code of ‘81 the process of ‘04 was larger and more complex. It consisted of editing by three committees (with several common members between them) before and during the Conference of ‘04, as well as a final approval of the IOMS before being published as a book of its own (El-Gendi, *The International Islamic Code for Medical and Health Ethics: INTRODUCTION*).

The process of producing the Code started before the Conference, through its one-year-long preparations (El-Gendi, *The International Islamic Code for Medical and Health Ethics: INTRODUCTION*). The first part of the Code started as a draft authored by Ahmed Rajai El-Gendi, by then holding the position of Assistant Secretary General of the IOMS' General Secretariat⁵¹. The draft was handed over to a first committee responsible for editing it into a semi-final form. This first committee was composed of 22 men, among them El-Gendi himself. The other men included 3 members of the Executive Committee of IOMS, the Secretary General of the IOMS, Mohammed Haytham Al-Khayat (a delegate from the WHO's Eastern Mediterranean Regional Office, EMRO⁵²), 2 representatives of the Law College of Kuwait, a member of the executive council of the Health Ministers organization of the Gulf Cooperation Council (GCC), the Secretary General of the Egyptian Physicians Association and the Dean of a Yemen Medical College (El-Gendi, *The International Islamic Code for Medical and Health Ethics: INTRODUCTION*; El-Gendi, 2005, pp. 459-483). As such, the committee represented *fiqh*, medical, organizational and cooperative authorities. The proto-version of the Code produced by this committee was then presented at the Conference of ‘04.

⁵⁰ This first reason refers to the large amount of contextual knowledge needed in order to properly analyze part 2 and 3 into the construction of the Speaker's authority. Including both part 2 and 3 would require knowledge of their specific process of production. In addition, part 2 would require a Speaker-analysis of the organizations who produced the foundational document used as a point of departure by the IOMS⁵⁰, as well as those organizations' participation in the Western-philosophical traditions on ethics. Part 3 would require a summary of the relevant *fiqh* in proximity and within the context of the IOMS. This would have to include an introduction to the terminology used, as well as to the history of the scholarly concepts pertaining to larger “Islamic” discourses of authority, mainly *fiqh* and the crossing between theology and jurisprudence.

⁵¹ See the introduction chapter on the organizational structure of the IOMS.

⁵² The organization with relevance to the production of the Code, including WHO-EMRO, will be examined in a later sub-chapter. The reason for this is to focus the examination of the “audience” within the Speaker-construct of 2004.

The Conference lasted 4 days, the 11th – 14th of December, and covered each of the Code's three parts as its main topics, first individually and then gathered at the end of the Conference. As such, the whole Conference was dedicated to the production of the Code, unlike the Conference of '81 where the Code of '81 was one topic among many used to create the IM- and IME-profile of the early IOMS. The first 3 days of the Conference of '04 consisted of 4 sessions, each between 75 and 120 minutes long, while the last day consisted of presenting the final versions of the three parts of the Code, the recommendations of the Conference and a farewell speech (IOMS, *Final Programme of the Conference*).

The semi-final form of the Code's first part was presented at the Conference of '04 on its first day, during the first 15 minutes of the second session, by Mohammed Haytham Al-Khayat; the aforementioned delegate from the WHO-EMRO, and a continuing member throughout all the committees responsible for producing the Code before and during the Conference. After the presentation of the semi-final Code, 6 speakers each got 15 minutes to comment on it. In the middle and at the end of the comments two larger discussions (90 and 105 minutes respectively) on the contents of the Code took place within the sub-committee of the Conference responsible for the first part of the Code (IOMS, *Final Programme of the Conference*; El-Gendi, *The International Islamic Code for Medical and Health Ethics: INTRODUCTION*; El-Gendi, 2005, p. 475).⁵³

This sub-committee consisted mostly of the same participants commenting on the Code. Most of them also figured in the first committee that produced the semi-final draft presented at the beginning of the Conference, including El-Gendi, Haytham al-Khayat, one of the representatives of the Kuwait Law College, the representative of the GCC Ministers of Health, and the General Secretary of the Egyptian Physicians Association. In addition, the sub-committee during the Conference also included a former Dean of the Kuwait Law College, a representative from a Biomedical Ethics Center in Virginia and 2 other attendants⁵⁴. In addition, Al-Awadi chaired one of the sessions (IOMS, *Final Programme of the Conference*; El-Gendi, *The International Islamic Code for Medical and Health Ethics: INTRODUCTION*; El-Gendi, 2005, pp. 459-483).

After being revised by Haytham Al-Khayat, the first part of the Code was submitted, along with the other two parts, to the final General Recommendations Committee of the

⁵³ The comments and discussion during the Conference were not made available on the IOMS' website, nor included in the English publication of the Code of '04. As a consequence, they are not included in the analysis in this study, due to being unavailable part of the Speaker-discourse. See the chapter on "Method".

⁵⁴ The introduction written by El-Gendi includes him and another speaker not mentioned in the program (IOMS, *Final Programme of the Conference*; El-Gendi, *The International Islamic Code for Medical and Health Ethics: INTRODUCTION*).

whole Conference. This last committee represented to a larger degree the structure and agenda of the IOMS. It consisted of 11 men, including El-Gendi, Hassan Hathout and 4 other members of the IOMS' Executive Committee and General Secretariat. The others included scholars of *fiqh* and law, at least two at some time affiliated with Kuwaiti institutions (including Abdel Sattar Abu Gheddah who also participated at the Conference of '81), and Haytham Al-Khayat from EMRO. The Code of '04 was then implemented and adopted by the IOMS as a final recommendation of the Conference (IOMS, *Final Programme of the Conference*; El-Gendi, *The International Islamic Code for Medical and Health Ethics: INTRODUCTION*; El-Gendi, 2005, pp. 459-483).

The publication of the Code of '04 in English includes a foreword by Al-Awadi, an introduction to the history of the Code of '04 by El-Gendi (both crediting the creation of the Code of '81 as an early milestone of the IOMS), and a further, and deeper introduction to the Code and its contents also written by El-Gendi. This last introduction, explaining the rationale of the Code, was revised by Al-Awadi and two other members/affiliates of the IOMS. The final version of the Code for publication was revised by the IOMS' General Secretariat, along with a resolution from the IOMS' Board of Trustees that the Code should be revisited every two years in order to append new relevant developments and contexts. The publication states on its front page to have been supervised by Al-Awadi and edited by El-Gendi (IOMS, *Final Programme of the Conference*; El-Gendi, *The International Islamic Code for Medical and Health Ethics: INTRODUCTION*; El-Gendi, 2005, pp. 459-483).

The Conference of '04 saw the participation of several other bodies contesting within different, but interrelated fields of ethics. The question is therefore: What led to IOMS attracting such an audience? Both the developments of the IOMS as a Speaker, and subsequent development of the profile of their audience is related to the contents of the Code of '04. I have therefore chosen to start with the chronologically first element relevant to the production of the Code. The next sub-chapter will as a consequence contain a summary of the IOMS' works during the 17 years between '81 and '04.

The background and developments leading up to the Conference of '04

In 1981, the organization of the IOMS was defined as the early key figures of the Conference and the Code, sponsored by a group of different Kuwaiti authorities (the Ministry of Public Health, the KFAS and the Amir), and its early inception constituted by Special Recommendation of the Conference of '81. As shown in the last chapter of analysis on the

Code of '81, the Conference of '81 thus *created* and defined a “Speaker” of the IOMS. I will in this sub-chapter describe the work of the IOMS as a Speaker from its adoption the Code of '81 and the Recommendations of the Conference as part of its claims to authority.

The IOMS was officially established under the patronage of the Amir of Kuwait, by Amiri Decree No. 18 in 1984 (Al-Awadi, *A Synopsis of the [IOMS]*). Independent of its official inauguration as an organization, the IOMS lists several arrangements during the years from '81 to '84 as a part of their activities (IOMS, *The Arguments of Islamic Law Rulings on Recent Medical Issues: Other Topics*). By the Conference of '04, the list the IOMS' activities consisted of seven “International Conferences on Islamic Medicine”, the first in '81, and the rest held in '82 (Kuwait), '84 (Istanbul, Turkey), '86 (Karachi, Pakistan), '88 (Cairo, Egypt), '98 (Istanbul, Turkey) and '02, in Kuwait (IOMS, *The Arguments of Islamic Law Rulings on Recent Medical Issues: Other Topics*).

The International Conferences on Islamic Medicine during the 80's dealt with themes including the status and importance of Muslim figures and the medical information found within Islamic tradition; the ethics relating to physicians; qualified authority on the field of IME and the implementation of IME in medical education; the prevention of threats to general health by “un-Islamic” and *haram* factors, and; the importance of medicinal plants. In addition, the definition of IM was addressed as a specific topic during the first 4 Conferences. These recurring themes usually went from being discussed in a general tone during the early Conferences and then developed into more detailed and specific discussions during the later Conferences, sometimes accumulating into agendas of “reform”, for example of medical educational systems (IOMS, *The Arguments of Islamic Law Rulings on Recent Medical Issues: Other Topics*).

A shift in the themes occurred during the late 80's when topics concerning global perspectives on medicine, ethics and organizational cooperation became prominent. This development accumulated into the Conference of '02 titled *Globalization and Its Influence on Health Development and Care*. It dealt with a larger variety of topics on “problems of globalization” relating to laws of intellectual property, provision of basic drugs on regional markets, and the effect of globalization on regional level institutions. These themes also dealt with a perceived necessity of socioeconomic considerations, reflected in the topics, including “Globalization, the Ecological Challenges for Public Health, and the Anticipated Changes in the Public Health Map”, “Overcoming Globalization Problems by Using the Natural Resources of Medicinal Plants, Research Development, and Attention to Generic Drugs”, and “Overcoming the Financing Problem and the Purchase of Necessary Equipment for

Developing Countries” (IOMS, *The Arguments of Islamic Law Rulings on Recent Medical Issues: Other Topics*).

During the years between '88 and '98 (the large gap between the 5th and 6th Conference) the IOMS held four seminars focused on heritage and a number of seminars focused on *fiqh*. A total of 14 seminars of *fiqh* were held between '83 and '02 under the banner of IOMS⁵⁵ (IOMS, *The Arguments of Islamic Law Rulings on Recent Medical Issues: Other Topics*). The list of the seminars on *fiqh* shows that the early arrangements were titled as concerning the status of life and death within Islamic jurisprudence, along with rulings on general ethics of the medical profession and assorted problems connected to its practice. From '89 and out the titles seem to reflect that each individual seminar was dedicated to narrower fields of ethical-legal deliberation, targeting specific contemporary problems of health and ethics.

Between its creation (counting from '81) and the Conference of '04, the IOMS had covered a large field of topics⁵⁶ through activities of *fiqh* and collective discussions across fields of scholarship. Many of the themes discussed centered on general topics within *fiqh*, such as the technical and spiritual definitions of life; lineage, and; ownership of the body and soul, and subsequent notions of the physical and spiritual integrity of the human body. The image of Islam presented at the Conference of '81 as a total way of life, and its perceived importance to dealing with contemporary problems, was enhanced and built further upon. Nevertheless, the *fiqh*-seminars also started developing a focus on the preventive and moral-based aspects of the IM-system. This focus was usually coupled with topics such as the humanitarian implications of dealing with AIDS, the increasing interest in the globalization of medicine and technology, and the need for socioeconomic justice in the distribution of

⁵⁵ Reproduction in Islam ('83); Human Life: Its Inception and End ('85); The Islamic View Concerning Certain Medical Practices, misc. topics ('87); Health Policy: Ethics and Human Values ('88); Patterns of Human Life and Their Impact on Health Development and Human Development in General ('89); An Islamic Perspective of the Implanting of Certain Human Organs ('89); An Islamic Perspective of the Social Problems Related to AIDS ('93); An Islamic View of Certain Health Problems: Skin Banks and Forbidden and Unclean Ingredients Used in Food and Pharmaceuticals ('96); The Medical Definition of Death ('96); An Islamic View of Certain Contemporary Medical Problems: Cloning, Fast Breakers, Transformation, Added Ingredients in Food and Pharmaceuticals ('97); Country-to-Country Consultations Concerning Psychological Health Legislation in Various Laws ('97); Heredity, Genetic Engineering, the Human Genome, and Gene Therapy ('98); the Rights of the Elderly from an Islamic Perspective ('99), and; Science in Islam in '01 (IOMS, *The Arguments of Islamic Law Rulings on Recent Medical Issues: Other Topics*).

⁵⁶ In an article in the Journal of the Islamic Medical Association (JIMA) in 2000, which is a reprint of a paper by the IOMS handed in to a conference by IMA in Birmingham, 1998, Al-Awadi summarized the topics as including (among many): medical and *fiqh* aspects of prohibited materials in food and medicine; cloning, genetics and genetic engineering; abortion, contraception and surrogate motherhood; transplantation of organs (including genital organs) and skin grafting; utilization of aborted fetuses and superfluous embryos from ART procedures in research; AIDS; alcohol and addictions to substances; spiritual components to healing, and; socioeconomic justice and the distribution of resources (Al-Awadi, 2000)

resources (Al-Awadi, 2000).

The IOMS' perspective on IM in general had not changed its focus. Al-Awadi stated in 1998 that past discoveries and teachings concerning the applications of medicinal plants needed to be evaluated according to contemporary modern scientific criteria. Islamic Medicine is defined, as it was in '81, as the complementary forces of both traditional and modern medicine: the historical findings and teachings by known Muslim scholars, as well as whatever medicine and pertaining ethics are taught in the Islamic sources, and; the medicine and ethics resulting in the filtration of said heritage through modern scientific methods (Al-Awadi, 2000, p. 69).

The publication of the Code of '04 includes an introduction and a foreword, by El-Gendi and Al-Awadi respectively, stating the background and rationale of gathering an International Conference on Islamic Medicine and once again producing and publishing a Code of IME. In both of these articles the core markers of the IOMS' perspective on IM and IME created in '81 are enhanced: they emphasize the importance of faith and spiritual components in healing, along with the scientific and technological advances of the last decades, in order to implement all aspects of health in a holistic view on medicine. In accordance with the Conference in '81 they also underline the need of moral guidance in order to prevent misdeeds and exploitation within medical practice and research (Al-Awadi, *The International Islamic Code for Medical and Health Ethics: FOREWORD*; El-Gendi, *The International Islamic Code for Medical and Health Ethics: INTRODUCTION*).

Referring to the developments of the IOMS, both articles praise the conception of the Code of '81, which according to Al-Awadi received papal blessing (Al-Awadi, *The International Islamic Code for Medical and Health Ethics: FOREWORD*). Nonetheless, according to El-Gendi the former novelty of the Code of '81 is confined to its own historical context. The changes within the status and possibilities of medicine, along with the developing use of computers and an even more collective nature of health care and treatment, has led to new ethical problems, such as risks concerning confidential patient information (El-Gendi, *The International Islamic Code for Medical and Health Ethics: INTRODUCTION*). Al-Awadi describes the developments of the IOMS as reactions to the changing contexts, and that the background of the Code is a culmination of these developments and works of *fiqh* (and thus ethics) by the IOMS during the last two decades.

Participants of the Conference: Individual numbers

Compared to the process of authoring the Code of '81, the process of '04 presents a larger

field of cooperation with other individuals and organizations. The following two sub-chapters are accounts of the participants of the whole Conference, including the levels of national, international and global agendas they represent, as well as which fields of knowledge and science.

According to the publication of the Code of '04, 222 individuals from 26 different countries participated at the Conference of '04. The two highest represented nationalities by far were Egypt (89) and Kuwait (32), followed by the U.S.A. (11), U.A.E. (10) and the Kingdom of Saudi-Arabia (10) (El-Gendi, 2005, pp. 459-483)⁵⁷. The list of participants in the Code of '04 contained far less details on their professional affiliations than national ones. A total of 78 participants did not include a professional affiliation (only listing country and/or municipality and address) or their professional information was too obscure. However, the largest clusters of professional affiliations that could be identified are still of considerable interest: 31 participants were primary affiliated with *institutions* of medical education or research; 21 with Medical or Physicians' *associations* (PAs) on international or national levels, and; 20 with a newspaper, journal or radio station (El-Gendi, 2005, pp. 459-483).

In addition, 11 different organizations and/or institutions of interest⁵⁸ were represented through the primary affiliations of 29 participating individuals. This means that a total of 50 participants represented an organization or association connected to the field of IME and the IOMS (El-Gendi, 2005, pp. 459-483).

By comparing these details to those of the participants at the Conference of '81, several changes within the Speaker-construct's "audience" are emphasized. First of all is the higher number of participants, including a higher participation from France, Italy, Germany, U.K. and Canada. On the other hand, the U.S.A. has a nominally smaller presence in '04 than in '81, a presence which becomes even smaller if the overall higher number of participants in '04 is taken into account. The massive representation from Egypt is of course noticeable, but so is the absence of any participants affiliated with India or Pakistan. The Code of '81 may not have focused on the specific role of traditional medicine (*tibbi/unani/advia* or Vedic)

⁵⁷ The other countries listed (and their participants) were Sudan (9), Syria (7), Tunisia (5), Jordan (5), Germany (5), Morocco (4), Malaysia (4), Qatar (3), Yemen (3), Bahrain (3), U.K. (3), Iran (3), Somalia (2), Oman (2), France (2), Indonesia (2), Libya (2), Italy (1), Palestine (1), Djibouti (1), Canada (1), and 2 not listed as affiliated with any nationality (El-Gendi, 2005, pp. 459-483).

⁵⁸ To be further examined under, these organizations were IOMS (11), WHO-EMRO (4), Ajman University Network (3), the Islamic Medical Center of Kuwait/IOMS (2), Al-Azhar (2, including Ahmed El-Tayeb, the *Sheikh al-Azhar* since 2010), Islamonline.net (2), the Islamic Educational, Scientific and Cultural Organization (ISESCO; 1), International Bioethics Committee under UNESCO (1), KFAS (1), the Council for International Organizations of Medical Sciences (CIOMS; 1), and the Islamic Center of South California, represented by their founder Maher Hathout who also participated in '81 (El-Gendi, 2005, pp. 459-483).

in itself, but its context implied a strong connection to these systems as historical roots and complementary systems within IM. In '81, India and Pakistan contributed with all 19 representatives primarily affiliated with traditional medicine; the list of participants in '04 contains no mention of specific institutions or organizations of traditional medicine (El-Gendi, 2005, pp. 459-483).

The Conference of '04 also had an increase in participants representing an audience of their own, through the large presence of mass-media and the large number of participants primarily affiliated with various PAs, representing various members and affiliations.

The 7 participants affiliated with institutions of *sharia* and law presents at least a nominal increase of that area of expertise since '81⁵⁹. In addition to the numbers and individuals already mentioned, an interesting cadre of international/global figures of traditional Islamic authority participated at the Conference of '04: Yousuf Al-Qaradawi (listed, but with no professional affiliations), Mohammad Mokhtar Al-Salami (the Grand Mufti of Tunisia) and Ali Gomaa (the Grand Mufti of Egypt). The authority of these figures has also been contested and questioned, and other interesting parties of traditional *fiqh* and of collective *ijtihad* were present as well (El-Gendi, 2005, pp. 459-483). Nonetheless, these names and positions exemplifies what kind of audience the Conference of '04 drew and related to, and what kind of authority the Code of '04 had to contest, and were contested by, in relating to them.

Participants of the Conference: Organizations and institutions

The organizations and authorities listed as involved in the organization of the Conference itself⁶⁰ were: the state of Egypt (represented by both the Prime Minister and the Minister of Health), the WHO-EMRO, the Islamic Educational, Scientific and Cultural Organization (ISESCO), the Council for International Organizations of Medical Sciences (CIOMS), the Ajman University Network, and the IOMS (IOMS, *Final Programme of the Conference*; Al-Awadi, *The International Islamic Code for Medical and Health Ethics: FOREWORD*).

As a sub-agency of WHO, the Eastern Mediterranean Regional Office (EMRO) works with governments, institutions, organization and other policy-makers in order to maintain and

⁵⁹ The large number of participants un-accounted for professionally might, for example, entail an even larger presence of participants specifically focused on the area of Priestly authority, and the institutions of "Islam". However, due to the difficulty of obtaining biographical information on the participants (see the chapter on "Method") such a conclusion would be speculative.

⁶⁰ As I have already noted, several institutions and organizations cooperated, or at least had members cooperating, on the Code both before and during the Conference. The organization stated here concerns the official endorsements, sponsorships and profile given to the Conference of '04.

develop health system and policies (WHO-EMRO, *About Us*). ISESCO was established under the OIC (known from '81 and through affiliations between the IOMS and the Jeddah-IFA) during the late 70's and early 80's. Its agenda consists of bringing about "Islamic Unity" through the strengthening of cooperation between the OIC member states within "[...] the fields of education, science and culture" (Islamic Educational, Scientific and Cultural Organization [ISESCO], *The Establishment of ISESCO*).

CIOMS is an international non-governmental organization founded jointly by two specialized agencies under the UN, the WHO and UNESCO, in 1949. One of the mandates of CIOMS is to maintain a collaborative relationship with the UN and its agencies, and as such, CIOMS, WHO and UNESCO are still official affiliates. According to their website, CIOMS started working on the professional ethics of biomedical research during the late 70's (Council for International Organizations of Medical Sciences [CIOMS], *Bioethics*). At the time the WHO was not "in a position to promote ethics as an aspect of health care or research", as it was prioritizing the organizing of health-care systems by the growing number of newly-independent member states (El-Gendi, 2005, p. 128).

CIOMS' research and work with ethics of biomedical professionals led to several publications, two of which are of considerable interest to the current study: the *Principles of Medical Ethics Relevant to the Protection of Prisoners Against Torture*, adopted by the UN General Assembly in 1983, and; the *International Ethical Guidelines for Biomedical Research Involving Human Subjects* (the Guidelines), last edited by the CIOMS in 2002 to include 21 guidelines concerning the ethical practice of experiments on humans. Among the central topics of the Guidelines were ethics regarding aspects of «informed consent», the facilitation of professional ethics to "vulnerable people"; children, people with mental or psychological disorders and pregnant women, and; the safeguarding of confidential material (CIOMS, *Bioethics*; El-Gendi, 2005, pp. 148-251).

The Guidelines are of special interest due to being the point of departure to the 2nd part of the Code of '04, titled as "an Islamic perspective" on the Guidelines of CIOMS⁶¹. The introduction to the 2nd part of the Code states several reasons for choosing the Guidelines as the basis for producing *Islamic* ethics of biomedical research on human subjects: (1) the work had already been translated into several languages, but not to Arabic. The IOMS' saw it as part

⁶¹ Preparing the «Islamic perspective» consisted of translating the text into Arabic in order to have a scholar of *fiqh*, Nazeem Hammad, identify the "Islamic rationales" of the guidelines. These were then examined by a group of scholars of *fiqh* (including al-Salami, the Grand Mufti of Tunisia), medicine and ethics in preparation for the discussions at the Conference of '04 (El-Gendi, *The International Islamic Code for Medical and Health Ethics: INTRODUCTION*).

of their work to do so, and make it available for Arab researchers of the field interested in the perspectives contained within the Guidelines, because; (2) the Guidelines were already widely in use by many countries having adopted the principles they included, and; (3) the Guidelines were deemed compatible with multiple cultures, as it was produced in a collaboration of about 200 scientists and specialists representing a multitude of fields of research as well as different nationalities (El-Gendi, 2005, p. 126).

The Ajman University Network was established as the *Ajman University College of Science and Technology* in 1988 in Ajman, the U.A.E., which then developed into a network of campuses, and is according to their website now “[...] a cutting-edge university, one which employs state-of-the-art technology, while at the same time, remaining grounded in the Arab culture and the traditions of the Middle East” (Ajman University of Science and Technology, *President's Welcome*). Other than sponsoring the Conference of '81, any further participation is not mentioned in the publication of the Code of '04.

Including the organizations and authorities mentioned above the Code of '04 lists 64 different organizations and authorities as participating at the Conference (El-Gendi, 2005, pp. 487-489). These included 18 different types of PAs, both national (11 different countries) and international⁶²; representatives of the Ministries of Health (MoH's) from 17 different countries, and; 11 different institutions of higher education, mostly medical (El-Gendi, 2005, pp. 487-489).

The KFAS distributed “IOMS prizes” during the opening ceremony of the Conference, and the publication of the Code of '04 is attributed to the state of Kuwait as a series of publications of the IOMS. The KFAS was not listed as a participating organization of the Conference of '04, suggesting that they sponsored the prizes given, but didn't take an as active role towards the proceedings in '04 as they did in '81 (El-Gendi, 2005, pp. i, 487-489; IOMS, *Final Programme of the Conference*).

In addition to the national and international PA's, MoH's and institutions of education, 13 other organizations and institutions are listed as participating. These include the ICSC (known from '81), 4 centers/committees of IME and bioethics (3 on a national level), the Islamic Centre for Population Studies at Al-Azhar, the Council of Arab Countries (the ACC, different from the GCC), the Executive Board of the Health Ministers Council for GCC states, 3 bodies of *fiqh* (*Dar Al-Efta/Ifta* of Egypt, headed by the Grand Mufti; the European Council

⁶² Defined as “Islamic” or general. One was the “Arab Physicians Association” of Egypt.

for *Fatwa* and Research, and; an “Islamic High Council” of undefined affiliation) and the Egyptian Red Crescent Society (El-Gendi, 2005, pp. 487-489).

The list of participants of the Conference also included Fawaz Saleh who’s primarily affiliation was being a member of the International Bioethics Committee (IBC) of UNESCO (El-Gendi, 2005, pp. 467, 487-489). The IBC was established during the mid-period of global bioethics, between the two Conferences of ’81 and ’04, in 1993, as a body of global bioethics under UNESCO. Islamic bodies of bioethics have been participating in its activities since its inauguration (Eich, 2011).

The profile of the audience and participants in '04 has both similarities and differences to '81. Hathout, El-Gendi, Al-Awadi, Abu Gheddah, Hossam Fadel and other participants from the Conference in '81 are listed as spokespersons or close affiliates of the IOMS (El-Gendi, 2005, pp. 459-483). Differences can be seen in the change of collaborators in organizing the Conference, the obvious being that it is held in Egypt, and not Kuwait. In addition, the Conference of '04 was held in cooperation with the organizations of WHO-EMRO, ISESCO and CIOMS.

The profile of these organizations shows a different international profile than of the Kuwaiti institutions, organizations and authorities involved in the organizing of the Conference of '81. This international profile is further emphasized by the other participating individuals and organizations: Together, they represent more *global* contestations on politics, Islamic authority and medical ethics than the audience’s profile in '81. In '81, the larger parts of the “international participants” were connected to the key-figures of the proto-IOMS and their interrelation through organizational works: El-Kadi, Hassan Hathout, Mohammad Said and Al-Awadi. In '04, the international profile of the Conference was many-faceted: The Executive Board of the GCC's council of Health Ministers was represented, as well as the ACC. OIC and ISESCO also represents a level of organization bordering on global aspects, but still centered on “Islamic” states.

Another type of global/international-profile lies in the presence and cooperation of the Grand Muftis previously mentioned and figures such Yousef Al-Qaradawi. The Conference also gathered different PAs, both national and international, of those a significant number “Islamic” PAs. The high degree of representation of organizations (also as primary affiliations of the individual participants of the Conference) attests to the addition of “organizational structures and cooperation” as a field of its own within the Speaker-construct of authority, complementing those of *fiqh*, history and medicine within the IM and IME of '04.

Coming back to the structure of the Code of '04, I propose to see the inclusion of the 3rd part of the Code as attesting to the historical development and activities of the IOMS described above. Considering the profile of the “audience”, the participation of larger figures of authority within the international and global, *sunni*-authority (such as the Grand Muftis) in the production of the 2nd and 3rd parts of the Code⁶³, enhances the image of the IOMS as a relevant contestant within a larger, international discourse on *fiqh*. The participation of CIOMS at the Conference can be explained by the inclusion and production of the second part of the Code. In addition, it attests to the closing proximity between CIOMS’ contexts and discourse as a Speaker of its own agenda to that of the IOMS, and its contemporary agenda on global and socioeconomic concerns.

The Conference of '04, its participants and the Code published as a result of it, represents the continuity of the Code of '81, but relating to a different context (coinciding with the relevant definition of “tradition” of the current study). When comparing the backgrounds of the respective Conferences of '81 and '04, the developments of the IOMS resulted in a larger and “heavier” Speaker in '04 than in '81. The 23 years of constructing a profile of authority resulted in both Priestly and Prophetic developments: the developments with regards to Islamic traditional authority, as well as the network formed in reaction to, and resulting in, the changing contexts, thus attracting the audience and participants of the Conference of '04.

Analysis of the International Islamic Code for Medical and Health Ethics

As previously stated, the Code of '04 consists of 3 main parts, centered on the themes of the ethics of the medical practitioner⁶⁴, the biomedical researcher, and the *fiqh* regarding medical procedures as developed by the IOMS since its inauguration. In addition, the Code contains an introduction spanning a total of 24 pages attesting to its nature of culminating two decades of organizational developments and work, when compared to the introduction of the Code of '81 of one page. The introduction not only contains a historical introduction to the Code, but also a longer explanation of the theological and legal aspects and concepts used within the main text of the Code. It thus constitutes a large portion of the message of the IOMS as a Speaker, and will be analyzed accordingly.

The introduction starts out by applauding the efforts of medicine in curing what was

⁶³ Among others were Al-salami and Abu Gheddah in the production of the 2nd part, and Ali Gomaa on the 3rd (El-Gendi, *The International Islamic Code for Medical and Health Ethics: INTRODUCTION*).

⁶⁴ The object of the Code is again implied to be male in its introduction.

earlier thought of as incurable, and the warding off of epidemics which were earlier to be counted as everyday risks of life. However, such applause is short-lived, as these developments of medicine and science also have negative aspects, such as the perceived dangers of reducing mankind to lab rats or storage of spare parts for the rich. The focus is centered on the integrity of the human body and soul, which are both endangered by unethical practices of medicine and research. Thus far the introduction basically re-states the necessity of an ethical medical practice in general, similar to '81 (El-Gendi, 2005, pp. 23–25).

The Code is in the introduction placed within the larger field of medical ethics, which also introduces an interesting change of elements in both the background narrative of the Code and the perspective on modern ethical systems, compared to the Conference and Code of '81:

“The most tragic incidence of callous medical practice was in the first half of the twentieth century, during World Wars I & II [...]. 'The Nuremberg Document' was issued in 1947 specifying a code of ethics that had to be adhered to when conducting research on man. This was followed by 'The Helsinki Declaration' issued by the International Medical Union in 1964 [...]. Then there was the 'Islamic Constitution of Medical Ethics' issued by the [IOMS] in 1982. There were also the International Guidelines concerning the ethics of bio-medical research including studies on human cases ([CIOMS]/WHO) 1995 – 2000” (El-Gendi, 2005, p. 24)⁶⁵.

First of all, the Code of '04 is being identified as a part of a global trend of developing medical ethics. Secondly, this trend is defined as beginning with the Nuremberg Code/Document and then the Helsinki Declaration. These need not necessary be seen as the only sources of the Code of '04, but the historical narrative presented is very different from the Avicenna/Averroes/Ibn-Haytham/etc. paradigm introduced as the common inspiration of medical ethics in '81⁶⁶. The change of profiles within the audience, and the closing proximity between fields of medical ethics, are therefore visibly reflected in the contents of the introduction.

Nevertheless, the role of Islam in ethics (and its importance in bringing about a revolution to implement concerns of the human soul into global medical ethics) is still factors of legitimization of the Code:

“[The Code aims to] Point out the disorder in the moral system and its physical and spiritual criteria. [...] an Islamic contribution to the subject of establishing moral rules for scientific research and applications will greatly enrich and enhance this matter on a world scale. The Islamic nation is quite qualified to make this contribution as the subject is in line with Islamic nature, beliefs, customs and traditions” (El-Gendi, 2005, p. 25).

The perceived dangers of unethical medical practice and research are mostly focused on their dangers to Man's dignity and the infringement upon “his sanctity” (El-Gendi, 2005, p. 42). In

⁶⁵ See the chapter on “Method” for more information on inconsistencies of dates/years. In short: I suspect the authors are using the *Hijri*-calendar when writing the original documents, which may be translated incorrectly

⁶⁶ The introduction to the Code of '81 mentions unethical use of nuclear fission, but no further connotations are given (Hathout/[IOMS], 1981, p. 733).

addition, modern developments of medical theory and technology are perceived as having led to the rights and duties of medical practitioners being undefined. This in turn has led to medical errors, and in the context of computers and technology of communication, to compromising the confidentiality of patients' information. The IOMS therefore saw it as imperative that elements of modern medicine and technology need to be examined, understood and made sure that they conform to the *fiqh* of the IOMS. In accordance with the general characteristics of the medical professional defined in the Code of '81, the introduction to the Code of '04 states that “The main objective of all these efforts is to make sure that a doctor is really God's means of bringing mercy to His servants” (El-Gendi, 2005, p. 42).

According to the introduction, the use of Islam as a source of morality creates an ethical worldview different to that of “Western philosophy”. The three monotheistic religions of Islam, Judaism and Christianity are defined as propagating a high standard of morals by the belief in God as the Creator of the universe, and that God's commandments are thus coinciding with “all human aspects and tendencies known only by Him” (El-Gendi, 2005, p. 39). Western philosophy, on the other hand, is conceptualized as a unified geographical area with several contradictory ideologies (such as capitalist markets with socialist democracy). Its ethics are defined as positivistic and based purely on tangible evidence, a moral system which sanctifies the individual and denies the existence of life after death, including the notions of God, Paradise, Hell and the Divine Revelation (El-Gendi, 2005, p. 40). As a consequence, the introduction emphasizes the gap between the moral imperative perceived within the Quran and other systems of ethics not grounded in a belief in a monotheistic “God”-concept: “In other words, the point of departure are so different that seeing eye to eye is almost impossible” (El-Gendi, 2005, p. 40).

Defining a clear system of values based on Islamic teachings and traditions to guide medical conduct is among the core topics of the Code's introduction, continuing the '81 agenda of inspiring and driving the Muslim doctor towards success based on his religious integrity. The introduction underscores several elements of the IOMS' profile known from the Conference and Code of '81: The importance of dedication towards the soul; the Quranic verse of “Whoso slays a soul [not for justified reason] shall be as if he had slain mankind all together; and whoso give life to a soul shall be as if he had given life to mankind all together”, which was prominent during the Conference of '81 and in the “Oath of the Muslim Physician” presented by the representatives of IMA; Allah as the origin of healing; ethics as the basis of *fiqh*, and *fiqh* guiding the application of ethics, and: the nature of those ethics as actually applicable to human behavior (El-Gendi, 2005, pp. 26 – 27).

Another core topic of the Code is stated as “Finding an alternative to the profiteering model that dominates the medical arena”, to remove any materialistic principles governing the lives of the medical professionals, and replacing them with *fiqh* in order to mete out socioeconomic justice (El-Gendi, 2005, pp. 26, 28). In the Code of '81, considerations of socioeconomic justice and the financing of medical practice were laid upon “the Nation” and “the state”, as well as “society” being tasked with maintaining the role and persons of the medical profession. In the introduction of '04, the focus has switched, from the external duties towards the medical profession, and the duties owed back towards society, to the malpractice of commercial profiteering by the medical profession due to a lack of Islamic guidance.

The introduction's explanation of the Islamic concept of morality defines “greed” as having an antithesis of “integrity”, “[...] a compound trait comprising readiness to help in an emergency or crisis, hospitality and understanding” (El-Gendi, 2005, p. 35). As such, the theme of exploitation and commercialism takes on a larger role than just nominal, monetary greed; commercialism defies the IOMS' perspective of Islamic society. The shift of focus between '81 and '04 is thus a matter of where the main weight of responsibility lies, with society ('81) or with the physician ('04).

In order to propagate a system of applied ethics grounded in the Islamic faith and tradition, the introduction includes a total 15 pages prioritizing the explanation of theological aspects of morality and “manners”/*akhlaq*. This includes an explanation of the relevant primary principles of theology and *fiqh* to the field of IME, as well as the secondary principles derived from the primary ones. These explanations are all exemplified and grounded in Quranic verses, *hadiths* and the *Sunnah* (with teachings and sayings also attributed to Ali Ibn Abu Talib and Aisha). Scholarly authorities of Islamic tradition like al-Ghazali, Ibn Manthour and Jalal Al-Din Al-Rumi are also referred to (El-Gendi, 2005, pp. 28-38, 43-46).

The explanation of the Islamic concept of morality starts with its definition as having to do with the inner image of Man, the soul. As such, the basis of ethical judgment lies in the dichotomy of good and evil, represented by virtues and vices, which in Islam are deemed to be universal, “[...] for good is the desire to elevate values, whereas evil is the opposite act of lowering and impairing them” (El-Gendi, 2005, p. 28). As such, the Code identifies the IOMS' as a Speaker and contestant in the field of global ethics on the side of universalism (as opposed to relativistic or pluralistic views on how global ethics should be constructed and maintained).

The soul is further explained as constituted by four “forces”: knowledge, wrath, lust

and justice. When all four forces are characterized by goodness, or used in cultivating virtues, a person is good mannered. The characteristics of a “well-mannered person” is, according to “some Islamic thinkers” (El-Gendi, 2005, p. 32), similar to the characteristics of the medical professional found within the Code of '81 including, but not limited to: humility, righteousness, piousness, truthfulness; non-boasting and wise in practice; not infringing upon the personal thoughts or lives of others unless called for; friendly, dignified and patient (El-Gendi, 2005, pp. 31 – 32). The forces of the soul are further linked to morality by propagating virtues through wisdom, courage, chastity and justice, or vices, through ignorance, cowardice, evil and injustice. Any other factors of the human personality and its traits are ramifications of these 4 main factors of the virtues and vices (El-Gendi, 2005, pp. 33 – 34). The introduction thus gives an account of the IOMS' concept of Islamic morality, one that was significantly deeper than the introduction to the Code of '81.

The last portion of the introduction handles the principles of *fiqh* the IOMS has derived the articles in the Code from. The first primary principle of *fiqh* concerns the fundamental nature of respect which is given to a person within the Islamic *sharia*, exemplified by the Quranic citation “We have honoured the Children of Adam” (El-Gendi, 2005, p. 43). The maxims derived from this are mainly three: “Sharia has stipulated the rights of human-beings”, “Man's right cannot be nullified without his consent”, and “Whoever is incompetent in action shall consequently be considered incompetent in words” (El-Gendi, 2005, pp. 43 – 44).

The second main principle identified is “achieving benefit”, or “the moral commitment to maximize benefit, neutralize harm to others and minimize unavoidable damage”, exemplified by the *hadith* reporting Muhammad having said “Neither get harmed nor bring harm to bear” (El-Gendi, 2005, p. 44). Derived from this are the maxims of “Any act that brings harm to bear or stands in the way of benefit is interdicted”, “[Acts of 'utter evil'] must be legally and rationally banned at all times and for all persons including notables”, and the principle of choosing the lesser of two evils⁶⁷ (El-Gendi, 2005, pp. 44 – 45).

The third and final principle consists of “the moral commitment to treat every person in accordance with what is morally correct and proper; giving every person, male or female, his/her what is due to him/her; and inhibiting greed and moral depravity in transactions [Sic.]” (El-Gendi, 2005, p. 45). This is appended by “Justice is settlement of disputes and controversies and equity; good-doing is attaining a benefit or averting a cause of corruption”

⁶⁷ Which also included opting for the greater good if two goods cannot be obtained at once (El-Gendi, 2005, pp. 44 – 45)

(El-Gendi, 2005, p. 45).

The Code of '04: Medical Behavior and Physician Rights and Duties

The first part of the Code of '04 consists of 107 articles divided into 10 chapters, or topics. These are: (1) The Physicians Ethics; (2) The Physicians Duties towards the Patient; (3) Medical Confidentiality; (4) The Physicians Duties towards Society; (5) Social Issues; (6) Advertisement and the Media; (7) The Physicians duties towards the Establishment he works at; (8) Relations with Colleagues; (9) The Physicians Rights, and; (10) The Physicians Duties towards his Profession (IOMS, *Part One: Medical Behavior and Physicians Rights and Duties [Part One]*).

Chapter number 5, "Social Issues", has been further split into sub-topics comprising the different specific topics of society and medicine the IOMS has been dealing with during the last two decades: the Utilization of Health Resources; Patients with AIDS or any other communicable disease; Euthanasia and Physician-assisted Death; Abortion; Organ transplants, and; Cases of violence (IOMS, *Part One*).

The structure of the Code of '04 is different from the one of '81, consisting of numbered articles presented first, and then, after a sufficient number of articles dealing with the same general principles or topics, a presentation of the "supporting Islamic Legal Evidence" deemed appropriate for the articles. The instances of "Supporting Islamic Legal Evidence" consist of either quotes from the Quran and a number of *hadiths*, or a number of legal maxims/principles of *fiqh*. The Quranic and traditional quotes attributed to the prophet Muhammad are introduced as "I. In the Glorious Quran: [between 2 and 4 citations]" and then "II. In the Prophet's Tradition: [between 2 and 5 key-citations from *hadiths*, and usually the name of the collection/collector/transmitter]" (IOMS, *Part One*). The references to *fiqh* and *sharia* are made like this: "The rules of the Islamic Jurisprudence (*Fiqh*) include the following: [between 1 and 3 primary or secondary principles as described in the introduction of the Code]"⁶⁸ or "The purposes of Islamic Law include [between 1 and 3 maxims representing 'the goals of the *sharia*']" (IOMS, *Part One*).

The change in the structure of the Code's contents seems at first glance superficial, but compared to the structure of the Code of '81, it does have an interesting impact: the numbering of the articles and the divide between articles and *fiqh*-evidence has the effect of

⁶⁸ The rules of *fiqh* sometimes included principles not specifically pointed out in the introduction, such as "intention is the criterion for action" (IOMS, *Part One*). The introduction does however underline several times that it is not exhaustive in its explanation of the theology and *fiqh* of the IOMS (El-Gendi, 2005, p. 38).

focusing their contents. The applied guidelines contained in the articles, and the legitimization of those guidelines found in the references to the Islamic tradition and the legal maxims, are given a stronger sense of being of an “applied” nature.

In addition, the language and concepts used in the articles are to a larger degree than the Code of '81 signifying general cases and contexts common to the physicians practice. The object of the articles is always referred to as “the physician”, and not nurses and other professionals within the medical profession as defined in the Code of '81. In fact, such other elements within the practice of health and medicine are usually explicitly addressed as an “other” element in relation to the physician (IOMS, *Part One*, art. 83, 84, 91, 92).

The language and concepts used serve to enhance the perspective given by the structural changes on the guidelines as having an “applied” nature, giving the Code of '04 a more specified approach compared to the Code of '81. Due to this more specified approach of the Code of '04, and the resulting large number of different cases deemed common to the practice of the physician referred to in the Code, a large number of articles cover the same general principles.

Themes of the Code of '04: The role and characteristics of the physician

The main theme of the Code of '04 centers on the role of the physician and the necessary qualifications and characteristics to the Islamic, ethical practice of medicine; it reflects the characteristics pertaining to the “well-mannered” person explained in the introduction of the Code of '04, thus reaffirming the general characteristics given in the Code of '81. These include a high level of integrity; gratefulness and sincerity in acknowledging the efforts of others; serving as an example by taking good care of his own health and appearance; refraining from lowering the esteem of his trade and his establishment of employment, both professionally and personally, and; piousness (IOMS, *Part One*, art. 1, 80, 81, 82, 101, 102, 105).

In addition, the Code of '04 reaffirms the “brotherhood” between physicians founded in the Code of '81: In a team of medical practitioners, the physician should foster constructive ability of the team and their performance (IOMS, *Part One*, art. 83); any problems inward should be solved constructively, preferably personally and friendly (IOMS, *Part One*, art. 84, 87); physicians are never to compete against each other over status or money, only complement each other weaknesses; when working together, the flow of information should be open and truthful between physicians, and directed by the primary attending physician of the patient (IOMS, *Part One*, art. 22, 24, 86, 88, 89, 90), and; physicians are to treat each

other and each other families for free in order to maintain an active medical workforce of society (IOMS, *Part One*, art. 85).

However, the new structure and language results in the Code focusing less on the characteristics of the physician, and more on his duties towards the patient and society. The point of departure, much in accordance with the Code of '81, is that the physician should not judge the patient based on any social, economic, religious or political grounds, and must treat the patient as an equal (IOMS, *Part One*, art. 2, 3, 4). As such, emergency treatment can never be declined by the physician, and any other treatment may only be declined if it is outside his competence as a physician (IOMS, *Part One*, art. 9, 10). The characteristics of honesty and openness are applied in the sense of explaining every necessary factor of illness and its treatment both clinically and preventative, in a manner that the patient can understand, and to continue treatment and consolation no matter the art of disease or illness (IOMS, *Part One*, art. 6, 11, 12, 13, 15, 18, 19, 25, 26, 51, 66, 69).

The goal of the physician's practice is less commented upon by the Code of '04 than the Code of '81, but in essence it remains the same: his responsibility is to extend treatment and care, but not necessarily to cure (IOMS, *Part One*, art. 96). The topic of "life" is also less commented upon, but mostly remaining the same as in '81; it is sacred, and should never be taken except in justified cases stipulated by the *sharia*, all of which are outside the domain of the physician (IOMS, *Part One*, art. 61). The goal of the physician and the theological definition of "life" contained within the Code of '04 do not emphasize the physician as a "soldier of life". The articles dispense with the rhetoric of the physician's characteristic as "God's tool for bringing mercy to Man", a compelling rhetoric used in the Code of '81. Instead, the physician's responsibilities towards "life" are mostly centered on practices which does *not* count as "mercy killing". These include: terminating a useless treatment, as long as it is "allowed by existing law"; declining to start a useless treatment, or; the administering of painkillers known to ultimately shorten the lifespan of the patient (IOMS, *Part One*, art. 62).

As a result of the cooperation with other global bodies of medical ethics, and the development of the IOMS, the Code of '04 includes a larger focus on the complexity of conceptualizing "the patient". The Code now contains several articles specifically dealing with different cases when the patient is a minor, an addict, a prisoner or infected with AIDS. For example, the rules of patient-physician-equality are to be applied and also appropriated to cases involving AIDS and other communicable diseases (IOMS, *Part One*, art. 57, 58); doubly so is the physician's duty to educate the patient on his disease in order to spare society of further HIV-infections (IOMS, *Part One*, art. 59, 60). References to the status and rights of

minors are mostly connected to issues of consent and confidentiality due to minors being legally deemed unfit for their own responsibility, or under legal guardianship. Should, for example, a minor ask to be treated in secret, the physician should further examine the reasons for this, and in most cases convince the minor to inform the family. However, if the family is incapable of understanding the necessity of treatment, or denying the minor proper medical attention, the physician may defend the minor's perspective and status, or refrain from revealing any information (IOMS, *Part One*, art. 27, 30, 31).

Another element of complexity has been introduced into the Code: The duties of the physician towards his patient and society are to be followed as much as possible when treating a patient who's addicted to substances, but also to observe "the laws in force", and implementing the use of special institutions aimed at that type of patients if necessary (IOMS, *Part One*, art. 28). Thus, not only "the patient" is made more complex, but also the context of practice, as the Code constantly refers to "proper authorities" or "the laws in force" seemingly external to the regulations and authority of the Code itself (IOMS, *Part One*, art. 28, 29, 31, 48, 59, 63, 81, 84, 94, 98, 104, 107). In turn, these stipulations further legitimize the Code within the context of such potential "authorities" or "laws".

Concerning the liability and responsibility of the physician, the Code of '04 maintains a general perspective from '81, but stated more explicitly: Consent is always needed for the treatment of a patient, either by the patient himself or a legal representative if consent is unobtainable, or the patient is deemed legally (according to the *fiqh* explained in the introduction) unfit. The exception is if an emergency occurs or the relevant disease is communicable and poses a threat to the larger society, when treatment is immediately necessary (IOMS, *Part One*, art. 14, 18). Overall, the complexity of the context of medical practice is given a wider berth through the exceptions defined in '04, to the general rules stated in '81.

The Code of '81 addressed the reduction of fees for the poor, and removing the socioeconomic divide when it came to access to medical treatment. In the Code of '04, the focus has been moved over to the prevention of any commercial exploitation by the physician of his practice, with regards to both patient and society. The Code clearly states ethical rules concerning the advertisement of the physicians practice and availability, such as reference to an establishment in which the physician holds shares. This must be done on the grounds of the high quality of medical service they provide, or access needed to otherwise unattainable resources and facilities for the treatment of the patient (IOMS, *Part One*, art. 20). As such, the patient's treatment or admittance to any medical institution, and any medicine prescribed to be

bought should always be on the basis of his health, and not of financial and commercial gains (IOMS, *Part One*, art. 20, 53, 54, 106).

In the case of organ donation, no procedures of donation or transplantation should be influenced by commercial factors, or the physician take part in such commercial traffic regardless of financial gains for him personally or not (IOMS, *Part One*, art. 68). In the public space, the physician is allowed to advertise, but only to truthfully inform of his actual skills and experience. Advertisement should never be resorted to in order to compete with other practitioners nor to commercialize medical practice, whether public or private. To be deemed lawful, advertisement need also be through appropriate media (such as databases and public information), especially if the physician practices at a private-sector institution (IOMS, *Part One*, art. 72, 73, 74, 75, 76, 77, 78, 79, 106).

The physician in relation to society, education and violence

The publication of the Code of '04 in English contains no emphasis on the terminology of *fard kifaya*. Otherwise, the general principles of the Code of '04 are once again reflecting the ones stated in the Code of '81: The physician should be an active member of society in promoting good behavior and practice (IOMS, *Part One*, art. 43); he should actively take part in public health and preventive medicine, including directing public lifestyles (IOMS, *Part One*, art. 44, 45), and; take an active part in creating positive health regulations and policies in society, as well as conserving health resources and administering them fairly, especially if holding an official position (IOMS, *Part One*, art. 46, 47, 49, 55, 56). In return, society must repay the physician by making available education and specialization, and through guarding the integrity and esteem of the physician's trade never infringing upon its character (IOMS, *Part One*, art. 94, 98).

Due to the topic of "social issues" a larger and more defined part of the Code's contents addresses the need for the fair distribution and utilization of health resources compared to '81. For example: A large part of the considerations deemed ethical when suggesting preventive and therapeutic procedures, approaches and policies are their cost and the number of patients benefiting from them, introducing the cost/benefit-ratio into the Code of '04 (IOMS, *Part One*, art. 56).

Topics of confidentiality, and society's ability to trust its physicians in matter of confidentiality, are to a larger degree emphasized in '04 than in '81; the text of the main chapter on confidentiality is itself 5 times larger than the section presented in '81. The general

rule in the Code of '81 still stands: Complete confidentiality reigns between physician and patient unless the contexts of society at large and/or family need to be applied (IOMS, *Part One*, art. 29). The Code of '04 contains a number of exceptions to the general rule, once again accentuating a larger complexity surrounding medical practice in the form of authority external to the Code: "laws in operation/force" and "judicial authority". Exceptions include the aim of preventing crime, and then only "official authority concerned" are to receive confidential information; the physician defending himself before a "judicial authority", or; to prevent the spread of disease and then only to the "concerned health authority" (IOMS, *Part One*, art. 29, 48). As a sign of the developing contexts and a larger area of influence, the Code of '04 also states that confidential information may be discussed with lawyers or insurance agents, but only the details relevant to the specific situations (IOMS, *Part One*, art. 34, 35).

Included in the topic of confidentiality are regulations on the correct handling of information on computers and in databases, including the need for consensual agreement from the patient when storing information in such a manner (IOMS, *Part One*, art. 36, 37, 38, 39). Strict rules concern the storage and availability of computerized information to the physicians and health care staff, along with the protection against unwanted access (IOMS, *Part One*, art. 41, 42).

The topic of education is mostly reflected in the themes of the necessity of medical specialization, medical licensing, surgical knowledge and capability, and the qualification of "complementary" systems of medicine to that of the modern/Islamic one.

First of all, the Code of '04 states that "A physician has the right to be provided by society with the means of training, acquiring scientific qualification, and drawing regulations that guarantee the high quality of health establishment and their performance, in accordance with internationally recognized standard" (IOMS, *Part One*, art. 93). This not only reflects the international and/or global profile of the participants, but also the relevant forms of medical education, emphasized by the following article stating the physician's rights to further education through conferences, seminars and similar arrangements (IOMS, *Part One*, art. 94).

Secondly, referral to a more competent or specialized doctors should be prioritized if it is the best for the patient's health. Referral to other doctors can also be relevant if the facilities which the attending physician has access lacks resources or equipment. Specialization, or the adaption of the treatment to the needs of the patient, also includes a physician's duty to investigate any suitable health-care programs relevant to the patient's affliction (IOMS, *Part One*, art. 7, 15, 17, 99, 100).

Two interesting articles should be emphasized: A physician should strive to upgrade both cognitive and scientific aspects of medicine, through continued education and research (IOMS, *Part One*, art. 101), and; “A physician should refer a patient to a practitioner of complementary (folk, traditional, alternative) medicine only when the latter is licensed to practice such medicine by the proper health authority” (IOMS, *Part One*, art. 104). Both articles represent a radicalization of the message of '81: Scientific methodology is the key to correctly implementing Islamic Medicine, and Islam is the key to correctly implementing modern medicine. The first article refers to the need for a continued development of the state of “medicine” in a positive direction, through modern systems of research and medicine. The second article quoted above refers to the negative delimitation of “medicine” to the systems accepted by “the proper health authority”; a harsher tone concerning the practice of *unani/tibbi* medicine than was used in the Conference of '81. However, during the production of the Code of '04, it should be taken into consideration that no participants from India or Pakistan were listed, and few Indonesians, the countries all practitioners of “traditional” medicine were affiliated with during the Conference of '81.

The focus on “war” from the Code of '81 has in '04 been switched over to cases of violence or torture. The Code of '04 thus mimics the language and topics of the other global bodies of medical ethics the IOMS had developed closer cooperation with, and who were participants in the production of the Code (WHO-EMRO and CIOMS). For example: Regarding the treatment of patients with “limited freedom”, or prisoners, the physician should not perform treatments amounting to torture or other inhuman acts of cruelty, nor be complicit to, entice or keep silent about such acts (IOMS, *Part One*, art. 25). Neither should the physician ever use his medical skills in procedures meant for interrogating such a patient in a way that would harm him, and he should report any such abuse to “the proper authorities” (IOMS, *Part One*, art. 25).

Speaker, Priest and Prophet

During the 23 years between the two Codes of '81 and '04, the developments of bioethics, medicine, science and the structures surrounding and contained within the IOMS have created a solid profile if the IOMS as a Speaker in the field of IME *and* global medical ethics. Analyzing the Code of '04 and comparing it to the Code of '81 reveals that the Priestly and Prophetic elements within the IOMS' authority are more defined and had a change of course in accordance with the development of the IOMS as a Speaker on IME.

The Code consists of two general forms of Priestly elements: The first is the

introduction which explains theology and *fiqh*. Through these explanations the Code legitimizes *why* the Islamic perspective of the IOMS on medical ethics is unique and important. The second element consists of the “legal evidences” within the Code. These Priestly elements are structured as arguments in favor of an Islamic perspective within the Code itself, meant to legitimize different groups of articles through different Priestly claims to authority. The second element is therefore designed to legitimize *how* the medical ethics are based upon Islam, thus legitimizing them.

Both types of Priestly elements constitute claims to authority. Considering the context, the relation to modern science and medicine, and the Speaker-construct of '04, the “legal evidences” are the more *explicit* claims of the two elements: They argue for the relevance of modern medical practices by showing its place within the Islamic tradition, and thus arguing for the relevance of the Islamic tradition itself.

Considering the few, but very noticeable articles referring to “complementary” medicine, the underlying tone is that of loyalty towards a scientific control over the concept of “medicine”. In fact, the object of the Code of '04, “the physician”, is typed as a surgical/clinical figure containing less psychological and behavioral elements than “the medical professional” of the Code of '81. This enhances the view of the Code of '04 as aimed towards physicians/doctors, and not containing the all-encompassing view of the Code's object as in '81, where all types of personnel within medical and health care were included as its audience.

Being structurally more accentuated, the elements of “Islamic Legal Evidence” within the Code reflect the contextual developments of the IOMS' own contestations on *fiqh*, as summarized by the introduction's explanation of theology and *fiqh*. Attesting to the developments of the IOMS' Priestly authority as a Speaker are such participants as Qaradawi, the Grand Muftis and the OIC, representing different takes on the globalization of *fiqh*.

The other result of a more defined and argument-based Priestly profile is that in the Code of '04, the physician is defined less as an object of religion (the sanctified doctor and his role as a tool of God's mercy in the Code of '81), and more an object of society. The Code of '04 further gives a general image of society, only referring to generic concepts such as “proper authorities” or “judicial authority” without specifying which and what kind. As a result, the Code implies a system of ethics applicable to any society, but where the physicians should still be subjected to religiously based ethics. The removal of such concepts as “the soldier of life” and “tool of God's mercy” included in the Code '81 enhances the aforementioned dual character of the Priestly profile of the Code of '04: Its argumentative and

more specified elements and the implied uniqueness of the Islamic perspective constructed by the introduction as over-arching the whole Code of '04.

The Prophetic elements of the IOMS' authority are more visible as the Code of '04 is to a larger degree immersed into a global context only glimpsed in '81. The Prophetic elements of organizational cooperation on global and international levels, and the corresponding approximation to other worldviews and *ethos*' are in '04 a fundamental part of the milieu the IOMS has to maneuver within. Science, computers and the collective methods of treatment are taken as already included in the system "medicine" instead of emphasizing a holistic concept, or "complementary" (traditional) systems. As a result, this concept of "medicine" is a starting point to the Code of '04, whereas for the Code of '81, it was a topic to be dealt with and concluded upon as a result of the Code and the Conference. IME are presented as more immersed within a larger field of medical ethics instead of being singled out through, for example, concluding the Code with an "Oath of the Muslim Physician" as in '81. The Prophetic profile is emphasized in the Code of '04 through its language and concepts, which changed with the emergence of the IOMS on to a larger field of global ethics during the 23-year span between the Codes of '81 and '04. This is reflected by the Code and Conference of '04 being identified as a product of cooperation where the WHO-EMRO and CIOMS are connected to UNESCO and the UN, and ISESCO with the OIC.

The conception of society and the medical profession was in '81 centered on the necessity of lowering the fees for the poor and applying them to the rich, in order to make medical attention equally available regardless of economic resources. In the Code of '04 and its introduction, the focus had shifted over to the threat of exploitation of the patient by the physician; a focus-shift from creating a social institution within the medical profession which would participate in breaking down the socioeconomic divide of rich and poor, to guarding against commercialism (and capitalism) as a motivational factor for practicing medicine. As stated in the analysis of the introduction of '04, "greed" has social implications within the teachings of the IOMS. However, the shift of focus emphasizes two changes within the perspective of the IOMS: the balance of responsibility between society and medical profession ('81) has been tipped over to become the responsibility and integrity of the physician alone towards society ('04). This in turn shows how the application of Islamic Medical Ethics have changed from constituting an ideology of its own and over to warding off an unwanted one instead.

In the Code of '81, the topic on violence was of the Doctor in War. In the Code of '04

the theme of physicians doing or preventing harm was centered on torture and interrogation, hinting at a focus on globally discussed humanitarian aspects (which were also introduced in the debate on the rights of AIDS-patients). Other humanitarian aspects of the global discussion on medical ethics are shown through the image of “the patient” becoming more complex. The approximation to other global ideologies of medical ethics is enhanced by the change of focus in the historical narrative of the Codes and of the IOMS, which in the introduction of ’04 is identified within the larger field of global ethics and the tradition of the Nuremberg Code and the Helsinki Declaration.

As a result of the developed Priestly and Prophetic profiles of the IOMS, the combination of the two is stronger and more emphasized. The differentiation of the individuals participating accentuates the “unified pluralism” of scholarly fields in the process of producing the Code of ’04 and the development of the IOMS’ *fiqh* in collective *ijtihad*.

The participating representatives of the larger field of global ethics and *fiqh*, as well as elements from the creation of the IOMS in ’81, attests to the point of this analysis of the construction of Islamic authority within medical ethics. The presence and work of Qaradawi, the Grand Muftis, Abu Gheddah, Hathout, El-Gendi, OIC, WHO-EMRO, CIOMS, ISESCO, and others, constitutes a larger convergence of Speakers representing several discourses within the field of global medical ethics and their relevant claims to authority, showing the multitude of voices relevant to the Code of ’04.

The conception of the physician in relation to society and the individual patient shown in the first part of the Code of ’04 embodies a larger contact between contexts and the application of several discourses resulting in an ontological pluralism entering the debate on IME.

Chapter 6: Conclusion of the study

The purpose of my study is to analyze the construction of authority of the two Codes of '81 and '04. The leading question of the thesis statement asked how these Codes were constructed with regards to both traditional Islamic authority and the context of medical ethics. Additional focus was thus given to identifying who took part in producing the Codes and influencing them, and how the elements of traditional authority and medical ethics were represented. Together, these parts of the analytical method sought to examine the relation between the Speaker-elements and their influence on the Codes.

This has been answered through analyzing the Speaker-constructs pertaining to the different contexts, and comparing them to the contents of the Codes in order to see how they reflect the elements of “author”, audience and context of communication. The Codes have been analyzed as containing Priestly and Prophetic claims to authority in order to describe how the elements of tradition and reform are intertwined when legitimizing their respective IME.

The Speakers

In chapter 2 I used Lincoln's theory to define the parameters of the discourses as the Speaker-structure, in order to see how discursive authority appears as a crystallization of the “author”, audience and context within the Speaker's message.

The Code of '81 started out as a draft by Dr. Hassan Hathout. However, the Code I analyzed was a document produced within a context set by many others: The Conference of '81 and its agenda were set by Al-Awadi and several institutions and authorities of the Kuwaiti state, which in turn gathered the participants of the Conference. The Code of '81 reflects these participants as framed by figures such as El-Kadi, the IME, the Hamdard Foundation and *Hakeem* Mohammad Said, and the early inception of FIMA. The standards and goals of producing IME were thus framed by an audience of international, pan-Islamic structures.

The Code of '04 started out as a draft within the organization of the Conference of '04 itself. As the Conference's agenda was based on the production of the Code, the nature of what I call Lincoln's common context of communication had changed: Regarding the Codes, in '81 the context was initially that of *presentation*, whereas in '04 it was always a context of *production*. The organizational structure of the Conference had also changed: The Egyptian state was involved, and Al-Awadi was still a key-figure, but the elements of the Kuwaiti state

had drastically lessened compared to '81. The most noticeable element was however the cooperation between the IOMS, WHO-EMRO, CIOMS and ISESCO as a *basis for the Conference itself*.

These differences between the two over-all contexts of '81 and '04 attest to the developments including the establishment of the IOMS and its subsequent 17 years of constructing solid claims to authority within the field of IME. These developments from the Speaker of '81 into the Speaker of '04 is reflected (and included) in the participants of the Conference of '04 and the Code: Compared to '81, the audience of '04 was larger both in size and profile; the participants in '04 represented a developed type of international profile (a large presence of medical associations) and included several actors with *global* agendas on medical ethics. In '81 the audience constituted different representations and contestations on Islam *as* universal ethics. In '04, Islamic universal ethics were represented, taking part and contesting within a larger discourse of universal ethics and *pluralistic views*.

Priest and Prophet

The other parts of chapter 2 concerned the theories of Weber, MacIntyre, Graham and Zaman. The purpose was to construct an analytical model which could conceptualize elements of traditional, religious authority and the context it is to be applied within.

The basis was the Weberian idealtypes of Priest and Prophet given roles as different types of legitimization in the claim to discursive, religious authority. Zaman, MacIntyre and Graham were further needed to operationalize both Priest and Prophet in order to describe the relationship between tradition and reform relevant to the current study. As a result the Codes could be analyzed as containing both Priestly and Prophetic claims to authority by first comparing the contents of the Codes with the elements of the Speaker-constructs.

The Priestly and Prophetic elements of the Code had developed in accordance with the development of the Speaker: Its claims to authority were more defined and structured as arguments within the larger context of medical ethics. In '04 the more specified teachings of *fiqh* and theology constituted a more defined Priestly profile. However, the Priestly authority and responsibilities of the medical professional himself lessened in favor of a role based on the rights of society. A secondary factor to this change is how the Codes' objects are defined differently: From the whole apparatus of medicine in '81 to "the physician" in '04.

The changes in the Priestly profile enhanced the role of the Prophetic elements of the Code, reflecting the composition of the Speaker. Compared to the Code of '81, the hegemony over defining the Code of '04's object is shifted over towards the context of medical ethics.

Prophetic reforms such as the change of language and concepts used in the Codes served to further develop the over-arching process of rationalizing the context of science and medicine.

In '81, the papers and participating organizations (along with an "Oath" of their own) were reflected in the Code of '81. In '04, an even stronger reflection was shown in the Code, of the organizations and their publication ratified on a global level. This in turn intensified the presence of an ontological pluralism within the Code of '04, which led to an enhanced Prophetic profile.

Regarding the result of the collective development of IME, one may ask the question of whether finding knowledge elsewhere "democratized" the process of interpretation. When comparing the instances of production and development represented by the two Speakers and Codes, the resulting over-arching process follows that of MacIntyre's "tradition": "It can also happen that two traditions, hitherto independent and even antagonistic, can come to recognize certain possibilities of fundamental agreement and reconstitute themselves as a single, more complex debate" (MacIntyre, 1988, p. 12). Within the construction of the current study, the collective development of IME as represented by the two Codes is not "only" a compromise, but a natural process of developing traditional authority.

Evaluation of method and materials

In chapter 3 I argued for the application of discourse analysis as a method in this study, along with the precautions of a contextual knowledge pertaining to a Master's level, and stipulations resulting in the study of mainly two constructions of authority, the Speakers of '81 and '04. Discourse analysis is a demanding process, but with the rewards of knowing how knowledge, meaning and authority are constructed socially. As a result it has been used to critically examine the obvious and explicit through the latent and implied.

I would also argue that the materials used give valuable insights into the process of constructing the authority of organizations and ethics continuously labeled as "Islamic". This includes the various stipulations given in chapter 3. In fact, variations in fields of knowledge are as defining to the production of IME as represented by the materials as they are to my own study: The idea of not knowing everything was constituent to the process of collective *ijtihad*. In turn, this means that the discourses of IME exist on the basis of both the divine purposes of the *sharia* and the influence of complementary fields of knowledge. This co-dependence between scholarly fields has been shown to take both explicit and implicit roles within the Codes of IME. As a result, it does not come as a surprise to see the discourse of a "tradition"

changing along with its context. This is seen for example in how the piety and “grace” of “the doctor” (Code of ’81) stopped being a theme of the Code once “Islam’s” relation to modern medicine was defined and taken for granted (Code of ’04).

Applications of the study

As contextual knowledge frames and constructs this study, complementary studies are crucial to the continuing study of the constructions of religious, Islamic authority. Should critical discourse analysis be taken to its fullest, an examination of the whole discursive field of IME would require continuous in-depth analyses of all organizations and individuals involved. As such, the “reality” of IME-constructions is inexhaustible and my own study is to a large degree illustrative of what such constructions may imply.

The application of the current study may be within several fields both within and surrounding the study of IME. Having “discursive authority” as its basis, it emphasizes the presence of several *ethos*’ and worldviews. The study is thus an example of how globalization contributes to discursive plurality and increasing reflexivity within the construction of Islamic authority. Further studies focusing more on the conceptions of the historical narrative of “Islam”, modernity and globalization-processes would provide interesting insights into the construction of both authority and identity.

Knowledge of how Islamic authority is institutionalized and constructed within the IOMS and their Code of IME is valuable in relation to several fields. In relation to global medical ethics it attests to the fact that changes within medical technology and worldviews necessitates the development of new medical ethics and choices of usage. The IOMS apply Islamic inspirational sources in order to create such specialized choices. Their construction is thus important knowledge when dealing with Muslims who would base their ethical decisions on their religious tradition.

In relation to the academic study of religion, this study describes IME as an *interdisciplinary field* with the engagement of medical anthropology, social sciences, *fiqh*, theology, and other sciences. Being contrasted with other fields, Islamic “law” and ethics are applied in a *broad* sense thus broadening the academic perception of “Islamic jurisprudence” in relation to “ethics”. Lastly, within the field of studying institutionalized Islamic authority, this study exemplifies how the constructions of such can further legitimize and elevate certain groups within a discourse to speak as the “voice of Islam”.

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Appendix: Abbreviations

- ACC – Arab Cooperation Council
- ART – Assisted Reproductive Technology
- CIOMS – Council for International Organizations of Medical Sciences
- The Code of '81 – *the Islamic Code of Medical Ethics*
- The Code of '04 – *the International Islamic Code for Medical and Health Ethics*
- The Conference of '81 – *the First International Conference on Islamic Medicine*
- The Conference of '04 – *the Eighth International Conference on Islamic Medicine*
- FIMA – Federation of Islamic Medical Associations
- GCC – Gulf Cooperation Council
- IBC – International Bioethics Committee
- ICSC – Islamic Center of Southern California
- IFA – Islamic *Fiqh* Academy
- ILL – Intra-Library Loan
- IM – Islamic Medicine
- IMA – Islamic Medical Association
- IMANA – Islamic Medical Association of North America
- IME – Islamic Medical Ethics
- IOMS – Islamic Organization for Medical Sciences
- ISESCO – Islamic Educational, Scientific and Cultural Organization
- JIMA – *Journal of the Islamic Medical Association*
- KFAS – Kuwait Foundation for the Advancement of Science
- MASA – Medical Association of South Africa
- MoH – Minister of Health
- OIC – Organization of Islamic Conference, later: Organisation (Sic.) for Islamic Cooperation
- PA – Physicians Association (including various Medical Associations)
- The Proceedings – *the Proceeding[s] of the First International Conference on Islamic Medicine*
- UN – United Nations
- UNESCO – United Nations Educational, Scientific and Cultural Organization
- WHO – World Health Organization
- WHO-EMRO – WHO's Eastern Mediterranean Regional Offices